The Journal

of the

Maine Medical Association

MAINE MEDICAL ASSOCIATION

The Ninety-Second Annual Session will be held at the

Poland Spring House, Poland Springs, Maine

June 24, 25, 26, 1945

Volume Thirty-six | January, 1945 | Number One

D

9 out of 10 cases of EPILEPSY are treated in the home

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, January, 1945 No. 1

*Trends in Public Health Planning**

Thomas Parran, M. D., Surgeon General, U. S. Public Health Service

The war has made it possible for the civilian health forces in the United States to push forward the attack against certain mass diseases with greater vigor than was possible in peacetime. The retreat of malaria, endemic throughout the southern part of the country, has been accelerated by the control program conducted by the Public Health Service in areas surrounding over 1,500 military and industrial establishments. At the present time, the disease is self-perpetuating in less than 200 counties in the entire country; and the malaria rate among troops based on the continental United States is the lowest in the history of the Army.

The national venereal disease control program has expanded in all its phases during the war. Approximately 40 percent of the men who gave evidence of syphilis at the time of Selective Service examination have been made available for military duty by means of follow-up, further examination, and treatment. A network of special hospitals for the intensive treatment of persons with infectious gonorrhea and syphilis has been established. In these rapid treatment centers, the newer methods for the treatment of these diseases are being evaluated, and are providing the means for accelerating the ultimate eradication of syphilis and gonorrhea in the United States.

The mass case-finding programs for the control of tuberculosis launched by the Public Health Service early in 1942 have demonstrated the value of the small-film X-ray. Since 1942, nearly 700,000 war workers and Government employees have been examined by our units, and 13 in every 1,000 persons examined showed evidence of reinfection tuberculosis. Most encouraging is the fact that in nearly two-thirds of the newly discovered cases the disease is minimal, so that the prognosis is excellent, with proper care and supervision. This is in sharp contrast with former case-finding methods; from 80 to 90 percent of the 90,000 patients now in sanatoria were not recognized as tuberculous until their disease was already far advanced.

Personnel assigned to State health departments by the U. S. Public Health Service have established programs of environmental sanitation, venereal disease control, maternal and child health, and control of acute communicable diseases in many parts of the country where basic public health services had not been pro-

* Presented at the 91st Annual Session of the Maine Medical Association at Rockland, Maine, June 27, 1944.

vided in peacetime. The Emergency Health and Sanitation program has also taught the Public Health Service and many States the necessity for inservice training of personnel.

The U. S. Cadet Nurse Corps is meeting the most acute needs of the military services, other governmental institutions, and civilian hospitals. Nearly 100,000 students have been enrolled in the Corps during the current year, and some 40,000 of these are now Senior Cadets, giving nursing care under supervision in hospitals and agencies which need their services.

Thus, during the war, we, in the United States, have seen increasing public health action by Federal, State and local governments. But in the face of increasing shortages of professional personnel necessary to carry on the work, it has been essentially a rearguard action.

The recent decision of military authorities to reduce their medical training programs by 50 percent, and the military needs which made it necessary for the Selective Service System to deny occupational deferment for premedical students, comprise a serious problem to national health. At a recent joint meeting of the Directing Board of the Procurement and Assignment Service with the Surgeon General, it was agreed that the situation was critical. The continuance of many medical schools is threatened. By 1945 the schools will have the impossible task of recruiting upwards of half their Freshmen among women and physically disqualified males. Entering classes in 1945 will probably be 30 percent smaller, with greater reductions ahead. The net result would be that only 3,500 doctors could graduate in 1948, as compared with an average of 7,000 annually under the accelerated program. Curtailment in the training of physicians will seriously impair the health of the nation for many years to come; and it further complicates planning for future improvements in the national health program.

We have realistically faced the fact that we must get along as best we can with insufficient personnel until the end of the war. That should not deter us, however, from making plans now for the future. When the fighting stops, health problems in this and other countries will become increasingly important. We may anticipate, therefore, a continuing increase in the responsibility of government for the health of its citizens. Careful planning now will enable us to meet that responsibility later.

During this century, the greatest reductions in death rates have been achieved in those diseases which have been the objectives of organized public health attack. Initially, public health action was directed toward the prevention of disease through sanitary controls. Later came preventive treatment through immunization and finally curative treatment of the individual, as in the case of syphilis and tuberculosis. Thus the public, through its government, has accepted increasing responsibility for the unprofitable sectors of medical practice.

As I see it, the next steps toward national health in the United States should have as their objective no less a goal than the provision of the best in health services and medical care for all people in all parts of the country. Equal opportunity for health, within the limits of inherited capacity, is the right of every citizen. This concept is implicit in the philosophy both of medicine and of democracy, and it is reflected by developments in other countries where plans for national health have been under discussion during the war.

Plans for national health should be integrated with other plans for social welfare. Social insurance, in its broadest terms, can contribute substantially to public health, as a means for pooling the risks of old age, unemployment, sickness and invalidity. National programs for better housing and improved nutrition also are closely related to health. However, much more is involved in the provision of adequate health services than higher standards of living and the pooling of funds to finance medical services. The primary elements in a national health program are the professional services and facilities necessary in the provision of complete health and medical care. The organization of these services into a workable program is extremely complex and it involves more than spreading the costs of medical care. The training and distribution of personnel adequate in numbers and quality and the provision of physical facilities, constitute the major difficulties which physicians visualize as barriers to the rapid extension of medical service.

On the other hand, neither public health nor medicine are static. Either spontaneously or

under outside stimulus, these two great social services go forward. Even the half-way measures used in public health practice have accomplished much; but only a fraction of what could be done if we applied the knowledge we now possess fully — up to the hilt — in every county, town and hamlet.

Public health in the United States has sighted realizable goals, and fortunately, we now have a sound organizational structure for the administration of public health services. Federal, State, and local administrative units are geared to work coöperatively. After the war, this structure should form the basis for the further expansion of health units to bring services to the remotest corners of our land.

Public sanitation — modern sewage disposal and water-supply systems — is needed in many parts of the country. Our goal should be to assure a sanitary environment in every home, factory, and town.

Malaria can be eradicated as a public health problem within a few years' time if we devote sufficient effort to the control of anopheline mosquitoes in our remaining endemic areas and provide mobile anti-anopheline units to control outbreaks in other areas, resulting from the introduction of new human carriers.

Tuberculosis can be drastically reduced or eliminated as a public health problem in a measurable time, if we use the X-ray to locate every case in the population — and I mean *every* case — and if we provide adequate facilities and personnel for the isolation and treatment of infectious cases. For the first time, our technological progress makes this goal practical.

Syphilis and gonorrhea can be brought under control much more swiftly than was anticipated six years ago, by the wider use of new methods and new chemotherapeutic agents. The prompt application of the newer knowledge in the treatment of venereal diseases is as much a result of the national control program as it is of need of the Army and Navy to control syphilis and gonorrhea among their personnel.

School health guidance and the correction of physical defects found in childhood are virtually untouched fields of prevention. The physical status of men examined for military duty in this war has again pointed to the failure of society in the conservation of child health.

Child-bearing can be made safer; more infant lives can be saved. Maternal and infant health services should be expanded to assure protection for these vulnerable groups of the population.

Industrial hygiene has been given impetus through war necessity. Developments in post-war industry will call for further expansion of the industrial hygiene program which should be placed on a firm footing so that it can take its rightful place in the general public health program — a place commensurate with its social and economic importance.

Preventive psychiatry which has made enormous strides in practical application during the war, should be an integral part of the national health program; and it should be used to reduce the enormous economic burden of mental illness, as well as to increase the social and mental adjustment of the population to post-war conditions.

Public health laboratories, if expanded and equipped with the best known facilities, should become centers to which physicians in all parts of the country could turn for prompt, accurate, laboratory and other diagnostic services.

Hospitals, health centers, and the like obviously must be made available, for without them, neither preventive nor curative services can be provided. Federal aid will be needed after the war in the construction of such facilities.

Research in the medical and public health sciences has been revitalized by the war; this renewed effort should not be allowed to subside. Expansion of clinical and experimental research is needed to provide new knowledge, further refinements in methods and agents for the conquest of disease.

Nation-wide campaigns against the great preventable causes of disability and death, which I have mentioned, will significantly raise the level of national health and reduce the risk of illness. But a great volume of unpreventable disease will remain. In planning for national health, complete medical services of the highest possible quality should be made available to all the people. This problem is so fraught with complications that the vision of both those who desire a complete medical care program and those who oppose it has been obscured.

Continued on page 7

*The Orthopedic Problem of the Crippled Child**

H. Leslie Wenger, M. D., New York City**

Students of poliomyelitis are confronted with a choice of material. They are being overwhelmed by a stream of printed material, both foreign and domestic, which confuses the already complex and sometimes bewildering condition of the crippled child. It is, therefore, necessary occasionally to stop to evaluate various contributions and attempt to formulate in one's mind a selective approach in planning the orthopedic attack to improve the function of a paralytic limb. The inventory of material can be properly used only when studied with a thorough knowledge of functional anatomy and underlying pathology. There should be no thoughtless empiricism. When this knowledge is further supplemented by a review of the historical development of orthopedics it even becomes a fascinating subject.

The epoch-making contributions of Sherrington in the physiology of reciprocal innervation of muscle was preceded by Hilton's work on "Rest and Pain." In 1903, Dr. Beevor presented an important contribution on muscle function when he gave his Croonian Lectures. In determining the exact localization of movements in the cortical areas of the monkey's brain, his attention was directed to the importance of noting the various muscles concerned in each movement evoked by stimulation of the cerebral cortex. It should be noted here that the brain knows nothing of individual muscles, only of movement. This fact contradicts one of the recent popular therapeutic concepts in the treatment of infantile paralysis.

The mechanism and management of muscles became a popular study both by the physiologists and anatomists. When this knowledge is combined with clinical observations, practical contributions to the surgery of the paralyzed victim immediately becomes apparent.

Here is an excellent example of the analysis of a patient's condition. A young girl was brought to Dr. Beevor with the trapezius on the right side atrophied below the level of the spine of the scapula. When she began to elevate the arm, raising it until it became horizontal, he observed that, as soon as the movement began, the lower angle of the scapula became prominent, the degree of winging increasing until the arm was half way up, at an angle of 45 degrees. Suddenly the winging disappeared. It became obvious that the function of the serratus magnus to maintain the scapula from rotating does not occur until the deltoid has moved the humerus through about 45 degrees. The lowest part of the trapezius is the proper muscle to maintain the scapula in advancing the humerus. When these fibres are paralyzed, the serratus magnus does not take over. However, it is further noted that when a shoulder joint is ankylosed, the serratus magnus begins to act as soon as the arm begins to be raised.

Such studies of the normal and disordered action of muscles exemplify that approach necessary in planning the orthopedic attack.

The problems can be grouped under these general headings:

1. Deformities of the thorax or torso.
2. Difficulties in walking.
3. Disturbances in function of upper extremity.

Although much work has been done for the severely deformed patients with curvature of the spine, there is still missing a completely satisfactory solution to the problem. The Hibbs-Risser procedure for correction by lateral flexion and spine fusion is well established, but is far from good. Recent contributions by Mayer on pelvic obliquity will undoubtedly aid tremendously the control of the balance of the torso, both in relation to scoliosis and to the patient's gait. Both he and Lowman are using fascial transplants, which are placed in the walls of the torso, connecting the pelvic rim to the lower ribs. Lowman uses a wide strip of fascia to reinforce the anterior abdominal wall in those cases of "pot-belly" deformity. Dr. Mayer has made use of similar broad fascial strips to strengthen the lateral abdominal muscles. The latter procedure combined with

* Presented at a meeting of the Androscoggin County Medical Association, May 18, 1944, at Lewiston, Maine.

** Assistant Professor of Orthopedic Surgery at the New York Post-Graduate School.

stripping operations to overcome the contractures, although a formidable procedure, is an extremely important contribution. It is far better for a patient to receive early orthopedic care, particularly to prevent fixed deforming contractures. The flexible spine and pelvis is much easier to handle, and the good results occur in this group of cases.

The presence of deformity due to changes in the bony structures or due to contractures makes orthopedic care more difficult, and frequently interferes with the ultimate functional result. A word of caution is necessary in correcting deformities of the thorax and torso. The motion of the pelvis should be considered in judging the amount of fusion extending into the lumbar spine. It is certainly better to do too little than too much.

The chief complaint of the patient is usually referable to his difficulty in locomotion. It is absolutely essential to observe the patient's gait. An analysis of his gait will reveal the major cause of the disturbance. One cannot hope to get a perfectly normal gait. Unless your surgical armamentarium is such that the operation will definitely improve the gait, it is better to use the best available appliance. One must consider the situation from the point of view of "what kind of a cripple you would turn him into." It resolves itself into finding out what sort of abnormal, but favorable, gait you can produce.

If a patient presents a picture of leaning forward at the waist, bringing the leg forward and using one hand on the thigh to support himself, you reach the conclusion that the patient has a quadriceps weakness. There is a disturbance in motion, power, and stability. One must make sure there is no fixed flexion contracture of the hip. No patient can cover up a limp due to paralysis of the gluteus medius or gluteus maximus. The lameness due to these two muscles takes precedence of all others and demands special consideration. For flexion contractures, a stripping operation is indicated. Either the method of Soutter or Campbell is quite satisfactory.

A limp due to gluteus medius paralysis consists of a sudden lurch to the side when weight is borne on the affected leg, very similar to that limp due to a short leg. Attempts to conceal this by some apparatus have proven entirely unsuccessful. In fact, it is safe to say at this time that no procedure known at present adequately replaces paralyzed hip extensors and affords normal stability, save arthrodesis of the hip joint. A patient will usually prefer an instable hip, plus preservation of motion, to stability and no motion. Only pain, or recurring subluxation, will make arthrodesis desirable. The transplantation procedures utilizing tensor fascia or the erector spinae, or shifting the gluteus maximus from extensor to abductor are all inadequate. The arthrodesis operation should, however, only be used if the patient makes the decision.

Inequality of length of the lower limbs is a frequent cause of limp. This can be remedied either by lengthening the short limb and, possibly, combining this procedure with epiphyseal ablation of the normal limb, or by shortening the normal limb. The work of Abbott and Phemister has been especially valuable in establishing this procedure and the end results in suitable cases have been satisfactory. Here, again, it must be noted particularly that a patient will not be relieved of his lameness by equalizing the length of his legs if there is a coexisting gluteus medius paralysis. The child's parents should be warned that the hip or abdominal involvement will not be materially affected by remedying the condition existing below.

The problem of the foot must be considered together with the alignment of the extremity. An existing knock knee must be corrected if an ankle or foot operation is expected to be beneficial. A tight contracture of the tensor fascia femoris is a common cause of knock knee. McKenzie Forbes and Yount pointed out the value of cutting the fascia near the hip or above the knee. It is often necessary to perform an osteotomy. X-ray studies should be made in determining the procedure. Studies of knock-knee cannot be made with the knee in the flexed position. After the leg alignment is made, then the hip condition is attacked. In general, posterior tenodesis operations are less satisfactory than other types of surgery about the ankle, because the tendon in this position must bear the whole thrust of the body weight at each step and too often stretches under these conditions.

When analyzing the foot deformities, one

must consider the joints involved in the production of the deformity and muscle imbalance which maintains and perpetuates the malposition.

The feet frequently are in equinus, calcaneous, inversion or eversion deformity. There may also be some intrinsic deformities.

Equinus and calcaneus deformities center about the ankle joint. Eversion and inversion occur in the midtarsal joints as well as the varus or valgus of the forefoot. The problems are many and vary with each foot.

The chief procedures must be based on correcting the deformities by surgery on the bone and then making use of tendon transplant to improve power. Muscle transplantation alone will definitely not control the condition of inversion and eversion or valgus and varus deformities.

A bilateral equinus deformity makes walking very awkward. A common error made by the inexperienced is the simple Achilles tendon lengthening for equinus deformity. If the anterior muscles are paralyzed, a flail foot results. In a child with a paralyzed or weak quadriceps and hamstrings good enough to prevent hyperextension of the knee, a foot in mild equinus is a definite asset. Such a set-up enables the patient to walk without a brace whereas if the equinus is removed and the normal amount of dorsal flexion is allowed, a brace generally becomes necessary for walking. The foot with moderate equinus deformity when placed on the ground in weight bearing, locks the knee in extension and the child is able to walk without a brace.

The bone stabilization operations that have established their place as excellent procedures are the Davis, Hoke, and Whitman operations. The detailed advantages vary with the individual problem. No routine operation should be used for all operations. The pan-arthrodesis of the foot is valuable when both hip and knee are in bad shape and a firm base is needed. The forefoot corrections must be planned with relation to the back foot. X-ray studies should be made before the operation and the exact site of the deformity noted.

Bone block procedures have proven worthwhile. These are used both in the knee and ankle. Campbell and Putti established the procedure as a valuable asset. Usually foot balance cannot be maintained by muscle balance, except possibly the equinus and calcaneus unbalance.

At the knee, the first problem is stability. Although arthrodesis is the best procedure, it is rarely done in children. Persistant pain, however, in spite of a brace is a definite indication for fusion, in the completely unstable knee. Consideration of the epiphyseal lines is important. A slight amount of recurvature should not be completely corrected, but should be limited. The bone block operations act as an olecranon.

The axiom "A knee is as good as its quadriceps" also holds in infantile paralysis. Hamstring and Sartorius tendon transplants are valuable procedures, and should be considered as previously described, i. e. in relation to the rest of the limb.

Upper Extremity

At the shoulder joint, one can state that the only worthwhile procedure devised to date is the arthrodesis. None of the other procedures have proved as good. The muscle transplant operations are numerous, and they usually involve the trapezius. Although it seems logical from the anatomical inspection that the deltoid origin is almost simultaneous to the trapezius insertion, the end results of that operation have not been as satisfactory as arthrodesis. Shoulder arthrodesis in the salute position is by far the most dependable reconstructive procedure. The position of the arm should, however, be changed to suit the individual muscle requirements. Analysis of the serratus magnus and subscapular function must be taken into consideration. The fusion operation offers better results in the younger patient because the child learns to accommodate through the new shoulder joint, i. e., the acromio-clavicular and sterno-clavicular joint. The minimum requirement for a shoulder fusion is a good hand.

At the elbow, the most practiced procedure is that of Steindler, who shifts the flexors of the wrist upward. Careful dissection of the flexor muscle and isolation of the median and ulnar nerves are necessary, and the entire mass is shifted proximally about 1½ inches. Most of the other operations have not been as satisfactory in improving flexion. Occasionally an arthrodesis at this joint is advisable, but the elbow should first be immobilized in a plaster cast as a test of function in the chosen position. Extension defect is rarely a problem.

At the wrist, arthrodesis is a valuable procedure. It should be remembered that in the wrist joint proper, palmar flexion and ulnar deviation occur; and that only these two motions are lost when arthrodesis is performed between the ramus and proximal carpal row. Dorsal motion and radial deviation occur in the intercarpal joints and will persist unless the fusion is carried through to include both rows of carpal bones. Various tendon transplants are often indicated at the wrist and, when combined with arthrodesis, have proved excellent. In a fused wrist, the wrist motors are freed and can be utilized in aiding the function of the fingers or thumb.

In the hand, oposition of the thumb is the most important function. The Bunnell or Steindler procedure is the accepted operation. Either procedure works fairly well in properly selected cases.

It is impossible to cover all the detail in such a review. No slight is intended if an important operation has been omitted. It is essential to approach the subject with the thought "What function is missing or deranged?" rather than "What operation should I perform?" Stereotyped surgery is poor surgery. The question in one's mind should be "What function is amenable to reconstruction with the tissues available?"

Trends in Public Health Planning—Continued from page 3

The distribution of medical personnel of all categories has also for a long time been a problem in this country. War has accentuated that problem. It would seem to me that when our doctors return from the war, we shall have an opportunity, never before presented us — and one which we hope will not come again in our lifetime — to help medical men to relocate in areas where they are most needed.

In the last analysis, we physicians must answer the public demand for complete medical and health service. In making that demand, the public should be able to say, as Mr. Churchill recently put it, "We claim the loyal and active aid of the whole medical profession."

I do not believe that *all* phases of a national health program require Federal financial support. The government should supplement State and local action; the full participation of the professions, the hospitals, foundations, and voluntary organizations must be the basis of any national health program. Out of my experience, I can visualize a partnership between Federal, State, and local governments and the professional and voluntary groups concerned.

Coördinated action of that type is the peculiar genius of our American democracy.

The public in its demand for medical services does not understand the reluctance of the professions to enter into a national program for medical care. The medical profession, on the other hand, is fearful that such a program may lower the standards of medical practice. I believe that the public, no more than the medical profession, would like to see a lowering of standards, but is insistent that service be more readily and more promptly available.

It is time, therefore, that leaders in medicine take greater responsibility for stimulating thought and guiding democratic action to achieve a satisfactory solution of the dilemma. If physicians do not take the initiative and discuss the problem rationally with others concerned, with the intention of solving it, they may find that representatives of the public have handed them a program to execute, and one which is not at all to their liking. Such was the case in New Zealand, and there the difficulties have not as yet been entirely resolved.

Group discussion of the whole complicated problem should lead to mutually satisfying answers. Hearings on legislation now before the Congress would afford an opportunity for all groups to present their views, with the result, it is hoped, that a sound and comprehensive program would be evolved.

The United States has the greatest number of well-trained doctors proportionate to the population of any country in the world; we have the finest medical institutions, and a position of leadership in medical research. But we have not made these services and this knowledge sufficiently available to the whole population. The people of this country have a deep desire for health, as a fundamental element in their concept of freedom. In the enduring peace which our nation with her Allies seeks to achieve, it will be the part of the medical and public health professions to enable every American to attain maximum health.

Editorials

Need of Sound Medical Care Studies Revealed by Survey

Discussing a survey of a section of Baltimore which revealed that patients with chronic disease had from three to four times as much medical care as did the other members of their families and the general population studied, *The Journal of the American Medical Association* for December 16 points out that "This interesting report again emphasizes the necessity for sound fundamental studies of the need for and cost of medical care in differently constituted groups. A large part of the medical care problem is the control of housing, diet and other environmental factors which affect the development of chronic diseases. From the information presented it could be deduced that any plan to spread the cost of medical care over the entire population studied would mean that a comparatively small group and one perhaps especially liable to chronic illness would receive a disproportionate share of the benefits."

The Journal says that "The Eastern Health District of Baltimore, which comprises two city wards containing about 11,000 white families and 2,800 colored households, was chosen for a five-year survey of chronic illness. This was considered reasonably representative of the type of locality in which an urban wage earning population lives. The following chronic diseases were included: manifest mental disorders, psychoneuroses, psychopathic and personality or behavior disorders; heart disease or hypertension; arthritis; diabetes; varicose veins; gall bladder disease; peptic ulcer; chronic nephritis; cancer; rheumatic fever; tuberculosis, and syphilis. Out of each thousand persons in the population of 5 years of age and older there were 32 cases of hypertension or heart disease, 18 cases of manifest and subclinical mental disorders, 16 cases of arthritis, 7 cases of rheumatic fever, 6 cases of diabetes, and 11 cases of other chronic conditions. This resulted in a total prevalence of these chronic illnesses of 90 per thousand of population. Families chosen because of a case of chronic disease showed an excess rate of illness among its members as compared with the other family groups. The rate of physician visits for these patients with chronic disease was 2,375 per thousand of population, or slightly more than two visits per person annually. The rate of clinic visits was 1,517 per thousand, giving a total of about four visits per thousand annually. The same population group had an additional 2.5 visits per person for illness not related to the chronic disorder. Patients with chronic disease, therefore, had from three to four times as much medical care (measured by the number of visits from a physician!) as did the other members of their families and the general population studied. Persons in the 381 'chronic disease families' formed 26 per cent of the total observed population, had 54 per cent of the total illnesses and received about 50 per cent of the medical care for illness given to the total population. Persons from these few families also constituted almost 40 per cent of the persons hospitalized during the second year of the morbidity study. . . ."

The Prevention of Measles

Human immune serum globulin, one of the fractions or components of blood plasma, is the material of choice in the prevention and modification of measles, Morris Greenberg, M. D., Samuel Frant, M. D., and David D. Rutstein, M. D., New York, report in *The Journal of the American Medical Association* for December 9. Their report is based on a study of the comparative effectiveness of human immune serum globulin, which they call gamma globulin, and of placental globulin, obtained from the placenta (the organ which surrounds the baby in the womb and is expelled at birth). The use of placental globulin in the prophylaxis of

measles was first introduced in 1933. Gamma globulin, one of the discoveries of our war research program, was used exclusively by our armed forces until last summer when a sufficient supply became available for its distribution to the public.

The three investigators say that gamma globulin was administered to 814 children between the ages of 6 months through 6 years who were in contact in their households with others who had measles. None developed regular measles, 78.7 per cent were completely protected and 21.3 per cent had modified measles. Among the latter, 92 per cent were mild and 8 per cent moderate. There was a tendency for the effectiveness to decrease with age. Untoward reactions were rare.

Placental globulin was administered to 90 similar contacts. Severe measles occurred in 23.3 per cent, 38.9 per cent were completely protected and 37.7 per cent had modified measles. Among the latter 70 per cent were mild and 30 per cent were moderate. Reactions occurred in 41 per cent of those injected.

In a group of 65 contacts who received no prophylaxis , 83 per cent developed measles, 31 per cent being severe, 12 moderate and 10 mild.

The three physicians point out that convalescent serum for measles is not as readily available and the comparatively large doses which are necessary make its use unpractical.

---

*Rehabilitation**

Rehabilitation has become almost a by-word since the advent of the War. It is discussed in papers and magazines, heard on the street, and was heard in campaign speeches. Individually and in groups people have become Rehabilitation conscious.

Of course what most have in mind is Rehabilitation as it pertains to Service men and women; their re-adjustment to civilian life, and feasible occupations.

Relatively unknown is the civilian program in human salvage which has been in operation for more than twenty years, and which has spread to every State and Territory in that time. Known as Vocational Rehabilitation, the program was initiated by Act of Congress in 1920 and financed by joint State and Federal appropriations. It is solely interested in handicapped adult men and women and their vocational adjustment. The original Act provided for vocational guidance, training, and placement of physically handicapped people, with provision of prosthetic appliances when needed for employment. Any adult man or woman of sixteen or over was eligible for consideration if hindered in obtaining employment because of physical impairment and if it seemed likely he or she could become self-supporting through the services offered by this program.

Clients included people who had been injured in industry so severely as to remain unable to return to former trades, public accident cases, and people disabled because of various illnesses or congenital troubles.

The benefits derived from such a program are two-fold. Not only are the clients themselves helped but their States and communities as well; for in many instances actual or potential public aid recipients have been enabled to become self-supporting. Many others, dependent on family or friends for aid, experience the thrill and blessing of being able to give instead of receive. It has been said that for each $1 spent in Rehabilitation $47 are returned to the community.

The early Rehabilitation program made a good start toward giving disabled people an equal chance along with the able-bodied for employment, a living, and self-respect for themselves and families. That its provisions were not enough was made evident in the National Health survey of 1935, which revealed that of some 800,000 persons severely disabled by accident or disease each year, 100,000 needed aid to enable them to return to some kind of remunerative employment. With defense needs boosting employment the Rehabilitation Divi-

---

* Presented before a meeting of the Cumberland County Medical Association, held in Portland, November 24, 1944.

sion in 1942 closed 40,000 cases in the whole country as rehabilitated. It was evident that broader provisions and more personnel would be required before the problem could be met to any successful degree.

Last year the earlier Act was amended—resulting in new provisions, broader interpretations, and funds for more adequate personnel. The present framework of legislation seems likely to be ample enough to provide a service of sufficient scope.

The expanded program provides these services:

1. Medical examination of every applicant before additional service can be rendered. The examination determines eligibility and feasibility of the client for service in the first place. Secondly, and sometimes most important is the fact that a thorough examination may reveal a second disability, unknown even to the client, which may have more bearing on the disposition of the case than the disability for which he was referred.

2. Physical restoration is another service of the new program. The general physical may reveal the advisability of referral to a specialist for further opinion. If the specialist advises that the disability can be appreciably improved by a specific type of operation or other treatment, with permission of the client, arrangements will be made for such treatment. In this State such arrangements can often be made through the regular State-aid channels. If the client is unable to qualify under State-aid, and does not feel that he can afford the expense himself, the Rehabilitation Division can finance the treatment up to a limit of ninety days of hospitalization.

3. Psychiatric and psychologic examinations can be secured.

4. Artificial limbs can be supplied when necessary for training and placement in employment.

5. Vocational training is supplied in various types of schools and trade shops—and through correspondence and tutoring. All training programs are constantly supervised.

6. The final step is placement and follow-up on the job.

The services of medical, psychiatric, and psychologic examinations, vocational training, and placement are available to any handicapped adult irrespective of financial status. The provision of maintenance during training, prosthetic appliances, physical restoration, and training supplies and tools is dependent on the ability or inability of the client to finance them himself without undue hardship.

The new program provides that mentally handicapped adults shall also be eligible for consideration. Little is being done in this State at present in this field due to lack of adequate facilities.

From the very nature of the group with which we are working, and the types of services we are offering, it can readily be seen that we are heavily dependent on the coöperation of the medical profession if we are to do an efficient, worthwhile job. Recognition of this fact has resulted in the establishment of a National Advisory Council made up of authorities from the various branches of medicine which are of primary importance to Rehabilitation — internal medicine, orthopedics, tuberculosis, psychiatry, industrial medicine, and physical therapy. This is duplicated on the State level. We have an advisory council here in Maine, headed by Allan Woodcock, M. D., of Bangor.

Whether you are aware of the fact or not, you medical men are guiding figures in our program. Through your diagnosis and prognosis, you determine whether or not the Rehabilitation Agent is going to accept a client. Your recommendations determine the level of activity the Agent will seek for his client. Your specialists make the decisions as to whether we are ready to initiate a training or employment program immediately or should try to minimize the disability by further treatment. Satisfactory results in an operation may mean the difference between a choice of a very few simple jobs or a chance to choose one of many. In some cases, particularly where the disability is tuberculosis or cardiac trouble, the Doctor is asked to set the initial length of hours of activity and then help us to graduate activity up to a normal day's length or as near that goal as safety will allow. The orthopedic man advises whether our amputation case is ready for his limb or not. In any case of serious disability the physician's advice is asked relative to the

training or employment goal under consideration, both for the immediate and more distant future.

Viewing the matter from another angle, we, the Rehabilitation workers, are helping the Doctor to follow through on his former patients, to complete the job of Rehabilitation which he started when he treated the client—for, after all, most Rehabilitation clients have at some previous time been under the Doctor's care for the same disability which brings him to us.

When John Smith injures his leg so severely as to necessitate amputation, the good orthopedic man looks ahead to the time when the man will be wearing an artificial leg and makes the amputation, as conditions will allow, at the point where the man will get the best residual use of the stump. That is fine. Now, is the man going to be able to buy a leg? And is he going to be able to return to his former job? Suppose he has always worked as a carpenter, and he loses the leg above the knee. How is he going to adjust and become self-supporting again?

Suppose Mary Jones is discovered to have heart trouble, perhaps as the result of rheumatic fever, which went almost unnoticed at the time. It may be that the Doctor is able to assure Mary and her parents that she can get along all right if she takes a little care and does not overdo. But Mary needs to work and wants to work, although her previous training and experience have not prepared her for any type of work which could be called light. What can she do to adjust to the new limitations? And similarly the same problem may arise in the case of a person whose tuberculosis has become arrested, but definitely indicates care in the selection of future jobs. And so, too, with numerous other types of disabilities which definitely affect the level and kind of activity in which the patient will be able to engage.

These are all instances where the Doctor has an excellent opportunity to advise his patient where to turn for help in making the vocational adjustment which lies ahead.

The time gap which occurs between medical treatment and the initiation of Rehabilitation services ought in many cases to be sharply reduced, oftentimes to the point where the two services coincide and Rehabilitation can be introduced almost at the bedside. We have a distinct service to offer many of your patients, and the more immediate the referral of them to us the greater the potential value of that service; for we will have an opportunity to work with clients whose morale has not had time to become too badly impaired by lapse of time and repeated disappointments. We will have prospects with higher morale, and the Doctor will have a better ally in his work—a patient whose courage has been increased by the knowledge that the future need not be as gray as he had feared. You, with your skill and patience, make it possible for these people to go on living in spite of severe limitations. With your help it is possible for Rehabilitation to show them living is still worthwhile and desirable.

New Army Bulletin on Gonorrhea

Penicillin is the drug of choice in the treatment of gonorrhea, according to a new War Department bulletin (TB Med 96). The use of sulfonamides, it says, will be limited to those cases not responding to adequate penicillin therapy and those instances in which penicillin is not available through normal supply channels. However, it is particularly important, the bulletin warns, that patients with gonorrhea treated by penicillin be carefully followed with respect to the possible development of primary and secondary syphilis which may be retarded or masked by the penicillin therapy.

Facts About Nursing, 1944

Approximately 208,000 registered nurses are serving civilians in this country, according to The Nursing Information Bureau of the American Nurses' Association. Another forty-eight thousand are in military service; of these nearly 23,000 are overseas. Departments of the Federal Government, exclusive of the Army and Navy, employed over 6,500 nurses in 1943, and the employment of over 7,500 has been authorized for the current fiscal year.

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Albert W. Moulton, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Waldron L. Morse, M. D., Springvale
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

100% Paid Membership for 1945
Piscataquis County Medical Society

Cumberland

The Cumberland County Medical Society met at the Eastland Hotel, Portland, Maine, on Friday, November 24, 1944, at 6.30 P. M. The meeting was called to order by the President, Albert W. Moulton, M. D. Resolutions on the deaths of Doctor Henry M. Swift and Doctor Mortimer Warren were read.

Mr. Elmer Mitchell, of the Vocational Rehabilitation Division of the State Department of Education, outlined the work that this division is doing, and what it hopes to do towards the rehabilitation of specifically handicapped individuals in the future. He emphasized that any plan to return the individual to a new and gainful occupation requires the coöperation of the physician, and that his department cannot learn of these individuals until they are referred to it by the physician.*

An interesting presentation of the chemistry and physics of welding, including the composition of electrodes, was given by Lt. Kenneth W. Nelson, Regional Health Consultant, U. S. Maritime Commission. His presentation was an introduction to the paper of the evening, "Health Hazards of Welding Fumes," which was given by Lt. Comdr. Walter E. Fleischer, Assistant Chief Health Consultant, U. S. Maritime Commission. He mentioned five different agents in the welding electrodes which may cause temporary illness of the individual. These were, namely, metal fumes fever from zinc oxide fumes; siderosis due to iron oxide, which is somewhat similar to silicosis but differs from it in that the individuals afflicted with it are not more prone to develop secondary infections, and furthermore the disease does not cause any impairment of the work capacity of the individual, and is symptomless. Chromium, because of the zinc chromate in the paint, causes a dermatitis. Lead oxide, due to the fact that red lead is used in painting ships, is a source of lead fumes. Fluorides within the gases cause a nasopharyngitis. He emphasized that cases of pneumonia are no more numerous in welders than in any other group in the shipyard. Following this a group of lantern slides which are ordinarily used to instruct welders as to methods of protecting themselves from fumes were shown. This paper was discussed by Drs. Babalian, Marchello, Porter, and Ward. Doctor Fleischer answered several questions and informed the group that the paper would appear in The Journal of the Maine Medical Association.**

A clinic at the Mercy Hospital preceded the meeting.

Joseph E. Porter, M. D.,
Secretary.

* Mr. Mitchell's remarks are published elsewhere in this issue of the Journal.

** The Journal of the Maine Medical Association, December, 1944—page 223.

Pay Your 1945 State and County Dues to Your County Secretary

Hancock

The annual meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, on December 10, 1944.

The meeting was called to order by the President, Philip L. Grey, M. D.

The following Officers were elected for the ensuing year:

President, Philip L. Grey, M. D., South Brooksville.

Vice President, Raymond W. Clarke, M. D., Ellsworth.

Secretary-Treasurer, James H. Crowe, M. D., Ellsworth.

Delegate to the 1945 annual session of the Maine Medical Association, Doctor Crowe. Alternate, George Parcher, M. D., Ellsworth.

Following the election of officers, Arthur P. Stebbins, M. D., of Bangor, read an interesting paper on *Electric Shock Therapy in Psychiatry.*

J. H. Crowe, M. D.,
Secretary.

Kennebec

The Kennebec County Medical Association elected the following Officers for the ensuing year at a meeting held at the Augusta State Hospital, Augusta, Maine, Wednesday, December 13, 1944:

President, Thomas C. McCoy, M. D., Waterville.

Vice President, Arch H. Morrell, M. D., Augusta.

Secretary-treasurer, Clair S. Bauman, M. D., Waterville.

Delegate to the 1945 annual session of the Maine Medical Association, Clarence R. McLaughlin, M. D., Gardiner. Alternate, Maurice A. Priest, M. D., Augusta.

Penobscot

The annual meeting of the Penobscot County Medical Association was held at the Bangor House, Bangor, Maine, November 21, 1944.

The following resolution on the death of Doctor Charles H. Burgess was read and ordered inscribed on the records of the Association:

> "With the death of Dr. Charles Burgess, medicine in Penobscot County suffered a definite loss. He was a sympathetic physician, a careful and skillful surgeon. He gave generously of his time and talents to the hospital. Younger men found him ready with advice and assistance and benefited by association with him.
>
> The Penobscot County Medical Association has pleasant memories of Dr. Burgess and deeply regrets his loss:
>
> Calvin M. Thomas,
> Samuel S. Silsby,
> Albert W. Fellows."

The report of the Secretary, Forrest B. Ames, M. D., showed a total membership of 85, consisting of 65 active members; in Service, 19, and 1 Honorary. During the past year, T. S. Moise moved to Connecticut, C. H. Burgess died, and Hans Shurman entered the Armed Forces. Eight regular meetings have been held and five special meetings sponsored by the Wartime Medical Post-Graduate Committee.

A nominating committee composed of Past Presidents, E. P. Goodrich, A. W. Fellows, and E. T. Young, presented the following slate of officers who were duly elected for the coming year:

President, Samuel S. Silsby, M. D., Bangor.

Vice President, George B. Weatherbee, M. D., Hampden Highlands.

Secretary-Treasurer, Forrest B. Ames, M. D., Bangor.

Board of Censors: Drs. M. F. Ridlon, J. J. Pearson, and J. E. Whitworth.

Delegates to the 1945 annual session of the Maine Medical Association: Leroy H. Smith, M. D., Winterport; Samuel S. Silsby, M. D., Bangor; Ernest T. Young, M. D., Millinocket; Martyn A. Vickers, M. D., Bangor.

Alternates: Hugh G. McKay, M. D., Old Town; Asa C. Adams, M. D., Orono; LaForest J. Wright, M. D., Bangor.

The Scientific Session was a meeting with the Medical Group of the Armed Forces; Wartime Graduate Series. The speaker was Ralph E. Wheeler, M. D., Professor of Bacteriology, Tufts Medical School. His subject was *Diarrheal Diseases.*

There were 37 present.

Forrest B. Ames, M. D.,
Secretary.

Piscataquis

A dinner meeting of the Piscataquis County Medical Association was held at the Blethen House, Dover-Foxcroft, Maine, November 16, 1944, at 6.30 P. M.

E. D. Merrill, M. D., President pro-tem, called the meeting to order following the dinner. The minutes of the previous meeting were read and approved. The District Health Officer, Charles Stanhope, M. D., invited the members to attend the Pediatric Clinics held at the Eastern Maine General Hospital, in Bangor, at 1.00 P. M., the third Friday of each month.

The President then called on Arch Morrell, M. D., State Pathologist and Director of the State Laboratory, who gave an interesting talk pertaining to his work, citing some facts that we will do well to remember.

The speaker of the evening was Roscoe L. Mitchell, M. D., Director of Health for Maine, who gave us an interesting paper on *The Health of the Public in Maine.* After the paper there was a question period which was well utilized by the members. The questions were thoroughly discussed by Drs. Mitchell, Morrell, and Stanhope.

The next meeting will be held at Doctor Merrill's home in Dover-Foxcroft.

H. C. Bundy, M. D.,
Secretary.

Necrologies

Charles H. Burgess, M. D., 1874-1944

Charles H. Burgess, M. D., 70, died at Bangor, Maine, September 22, 1944, following a short illness.

He was born in Winn, Maine, the son of James H. and Sarah Gibbs Burgess. He was graduated from the Maine Medical School in 1898.

Doctor Burgess was a member of the Penobscot County Medical Association, the Maine Medical Association, the American Medical Association, and the American College of Surgeons. He was a member of the staff of the Eastern Maine General Hospital in Bangor for many years. For the past seventeen years, Doctor and Mrs. Burgess have operated the Stinson Private Hospital.

He was a physician and surgeon of ability and was well known and highly respected in his profession by all who knew him.

He is survived by his widow, Mrs. Ida S. Burgess.

Estes Nichols, M. D., 1874-1944

Estes Nichols, M. D., 70, died at his home in Portland, Maine, December 12, 1944, after several months illness.

He was born in Boston, Massachusetts, August 10, 1874, the son of Austen Leroy and Josephine Bond Nichols. He attended Bates College and was graduated from the University of Vermont Medical School in 1900. He was in Public Health and Marine Hospital service until 1902 when he came to Portland to begin general practice.

Doctor Nichols served in the Army Medical Corps in the Spanish-American War and in World War I, attaining the rank of Colonel. In World War I, he became a consultant of lung diseases at the Department Headquarters at Boston, and was later Director of the School of Lung Diseases at the Army Medical School, Washington, D. C., Director of the School of Internal Medicine, Fort Oglethorpe, Georgia, and Commander of General Hospital, No. 16, at Allentown, Pennsylvania.

He was a member of the Cumberland County Medical Society, the Maine Medical Association, the American Medical Association, the American Climatological Association, and a charter member of the American Tuberculosis Association. He was Vice President of the Maine Public Health Service several years, a member of the National Rehabilitation Committee of the American Legion, special consultant of the U. S. Veterans' Bureau and Chairman of the Rehabilitation Committee of the First District. He served eleven years as Superintendent of the Maine State Sanatorium at Hebron.

He is survived by his widow, the former Charlotte Woodman Flint of Dover-Foxcroft, and one son, Estes Flint Nichols, now with the U. S. Infantry in France.

Langdon Trufant Snipe, M. D., 1867-1944

Langdon T. Snipe, M. D., 77, a former President of the Maine Medical Association, died at his home in Bath, Maine, December 13, 1944.

He was born in Boston, Massachusetts, May 27, 1867, the son of Seth T. and Anna Maria Spinney Snipe, but lived practically all of his life at Bath. He was graduated from Bath High School and from Yale University. He attended the Maine Medical School one year and was graduated from the College of Physicians and Surgeons of Columbia University in 1893. He did postgraduate work at Bellevue Hospital and later that year returned to Bath where he had since practiced.

Doctor Snipe was an Honorary Member of the Lincoln-Sagadahoc County Medical Society and the Maine Medical Association, and a member of the American Medical Association and the American Academy of Medicine. He was a member of the original staff of the Bath Memorial Hospital, and was dean of its staff at the time of his death.

He was prominent in Bath business and civic life.

He is survived by his widow, the former Christina Carter.

Notices

Members Elected to American College of Surgeons

The following members of the Maine Medical Association were accepted as Fellows of the American College of Surgeons in 1944:

Waldo A. Clapp, M. D., Lewiston.
Philip O. Gregory, M. D., Boothbay Harbor.
Roderick L. Huntress, M. D., Portland.
Eugene P. McManamy, M. D., Cape Cottage.
Albert P. Royal, Jr., M. D., Rumford.

NBC Network Presents "Doctors Look Ahead"

4.00 to 4.30 P. M., Saturdays, beginning January 6th and continuing through June 30th.

"Doctors Look Ahead," presented in coöperation with the American Medical Association.

A series of dramatized episodes devoted to medical progress and research at home and abroad. Dramatizations will be followed by a two-minute summary, generally in form of interviews.

Initial show entitled "Doctors at War." Speaker—Dr. W. W. Bauer, director of Health Education, American Medical Association.

Additional broadcasts thus far scheduled:

January 13th — "Pneumonia" — speaker not yet known.

January 20th — "Sulpha drugs" — speaker — Dr. Austin Smith, secretary, AMA Council on Pharmacy and Chemistry.

January 27th — "Penicillin" — speaker — Dr. Austin Smith.

State of Maine Board of Registration of Medicine

Adam P. Leighton, M. D., Portland, Secretary.

List of Physicians Licensed by this Board, November 15, 1944.

Through Examination

Carl Edwin Andrews, M. D., Portland, Maine.

Prince Drummond Beach, M. D., New Bedford, Massachusetts.

Eleanor Crissey, M. D., New York City, New York.

Francois Paul Methot, M. D., Lewiston, Maine.

Through Reciprocity

Joseph G. LeBrun, M. D., Somersworth, New Hampshire.

Lester Neuman, M. D., Washington, D. C.

Alice Jordan Shubert, M. D., Bangor, Maine.

Sabine Holin, M. D., Greenwood Mountain, Maine.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*
St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Acting Director, *Joseph E. Porter, M. D.*

Waterville: *Sisters Hospital*
1st & 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*
Thayer Hospital
2nd & 4th Thursdays, 10.00 A. M.
Director, *E. H. Risley, M. D.*

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Rockland, Rumford, Sanford, Waterville, Wilton, Millinocket, Old Town, Portland, Presque Isle, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.

Book Reviews

"A Textbook of Pathology"

By: Robert Allan Moore, Edward Mallinckrodt Professor of Pathology, Washington University School of Medicine, St. Louis, Mo.

With 513 illustrations, 34 in colors.

Published by W. B. Saunders Company, Philadelphia. Price, $10.00.

In considerable detail, Professor Moore discusses in this absorbing text the pathologic anatomy in its relation to the causes, pathogenesis and clinical manifestations of disease. Actual photographs, together with an occasional diagram and drawing, amplify carefully conceived word structures in the professor's discussion of salient points.

Insofar as possible, the author seeks, and apparently he succeeds, in producing answers to the all important questions of "How?" "What?" and "Why?" as they concern certain diseases. He includes in this work much of a controversial nature in a discussion of causes and treatments, but this deliberate effort stimulates rather than retards the thinking of the reader.

The lengthy volume — it runs to more than 1,300 pages — is offered through classification of diseases with similar causes, hence the book has value for easy reference.

A section is devoted to preventive medicine because, in the author's own words, "preventive medicine will play an important part in the future of medical science."

"Operations of General Surgery"

By: Thomas G. Orr, M. D., Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas.

With 723 pages, including 1,396 step-by-step illustrations on 570 figures.

Published by W. B. Saunders Company, Philadelphia. Price, $10.00.

Intended to serve the dual purpose of bringing advice and caution to the beginner and words of reminder to the veteran general surgeon, Dr. Orr's text virtually "hits the spot."

Surgery, both the common and the rare, come in for detailed discussion as the author seeks to impart his belief that general surgeons should be informed in the special fields of surgery in event of calls in periods of emergency.

Dr. Orr includes in his volume a chapter on Wound Healing and another on Treatment of Fresh Wounds because he clings to the suspicion that "the teaching of wound healing and wound treatment," was never more important than now.

The 21 chapters follow a chronological pattern to include, in succession, discussions of allied systems.

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, February, 1945 No. 2

*Recent Developments in the Treatment of War Casualties**

D. W. Lyon, Captain (MC), U. S. N., Executive Officer, U. S. Naval Hospital, Portsmouth, N. H.

Carrying on a war such as the one in which we are now engaged consists largely of amphibious operations against an enemy strongly entrenched on ground thousands of nautical miles from our source of supplies. This is especially true in the Pacific theater where the establishment of a beach head only gives us an island base from which we must continue our amphibious assault on the next island. This type of warfare involves employment of the Navy on a scale unprecedented in history.

The ground forces carry their own Medical Department personnel and equipment and are responsible for the treatment and evacuation of casualties to the high tide level on the beach. From that point the sea forces "take over." Efficient care and early evacuation of these casualties requires not only careful planning on the part of both forces but the utmost coördination between them. As most of you undoubtedly know, the Marine Corps has no Medical Department and Navy Medical Officers and hospital Corpsmen accompany them in the field. The organization of the Medical Department accompanying such forces is comparable to that of the army so that a picture of how we handle these casualties will undoubtedly reflect a fairly accurate picture of army practice.

All men going into action carry a first aid packet which contains in addition to the sterile battle dressing, two 1 gram tablets of sulfadiazine and an envelope containing 5 grams of sulfanilamide crystals. They have been instructed to take both tablets of sulfadiazine immediately, if wounded, and often have taken them before the arrival of medical personnel.

The first assault wave ashore is accompanied by company first aid men — enlisted hospital corpsmen. These men render first aid to casualties where they occur, they check hemorrhage, sprinkle sulfanilamide in the wounds, apply sterile dressings and temporary splints if necessary, give morphine, tag the wounded and move on. With the supporting wave comes the battalion aid station with Medical Officers and additional corpsmen. Stretcher parties are organized to bring wounded to the aid station, where dressings are checked, Thomas splints applied and plasma is administered to those in shock. When a sufficient beach head has been established a collecting party is landed along with support troops and motorized equipment. Jeeps, converted into ambulances, are sent for-

* Presented at the Annual Meeting of the Maine Medical Association at Rockland, Maine, June 27, 1944.

ward to the battalion aid station to bring the casualties down to the collecting station which has been established on the beach. Here the wounded are given further treatment if needed, minor cases are returned to the front and serious cases evacuated to transports via ambulance boats, or, more often than not, by landing craft returning to the ships for more troops or mechanized equipment. When the beach head has been sufficiently well established the collecting party is augmented and a Field Hospital set up. Here urgent major surgical procedures can be carried out after the facilities afloat have left.

Meanwhile transports have been readied for the reception of wounded. All transports have well equipped operating room facilities. Certain transports, especially well equipped and staffed for handling the more serious casualties, are designated as auxiliary hospital ships. Here the abdominal, head and thoracic wounds get their first real surgical care and compound fractures can be debrided and put up in plaster enroute to an advance base hospital or hospital ship which may be 2 or 3 days' steaming distance away.

As soon as an air strip is established casualties are flown to advance base hospitals. It has been proven highly practicable to evacuate all types of casualties by air providing adequate first aid treatment has been applied and provided not more than 4 or 5 hours' flying time is required. Altitudes of over 3,000 feet are not without danger to those with chest and abdominal injuries. While the administration of oxygen at higher altitudes is of great value in chest injuries, nothing has been found to counteract the effect of high altitudes which promotes distention in those with peritonitis or ileus. All other types of wounded including those with intracranial injuries can be flown at altitudes up to 10,000 feet without ill effects. Extensive burns stand air transportation well, if they have been well fortified with plasma and treated for shock for 24 hours prior to evacuation. Cases with profound anemia as a result of hemorrhage, or secondary to malaria or malnutrition, have withstood altitudes of 8,000-10,000 feet remarkably well. No difficulty has been experienced as a result of prior sulfonamide administration which is given to virtually all those with gunshot and shrapnel wounds. With morphine, plasma and oxygen on the planes, most casualties can be safely evacuated by air. After air ambulance service has been established, the majority of these casualties reach base hospitals 600 or 700 miles from the scene of action in 12-48 hours after they are injured.

In purely Naval engagements the early handling of casualties is somewhat different. On a combatant ship water tight integrity is of paramount importance because the ship must remain afloat in order to carry on her mission of engaging the enemy as a fighting unit. To insure this water tightness, the ship is divided into many compartments, and water tight doors and hatches are dogged down during action. The safety of the ship cannot be jeopardized by opening these doors and hatches to handle wounded. Medical department personnel and equipment are widely dispersed throughout the ship; partly to be able to render first aid where needed, but chiefly to avoid the irreparable loss of a large percentage of either personnel or material by one fortuitous shell or bomb. Many compartments, of course, are without medical personnel, but all hands are thoroughly trained in first aid. First aid boxes, available to all throughout the ship, are kept stocked at all times. It is the practice on most ships to distribute morphine syrettes to a considerable number of non-medical officers and enlisted men, who have been specially instructed in their use. These men are so chosen that all battle stations, no matter how isolated from other parts of the ship, are supplied. The immediate availability of morphine for all wounded, not only helps to prevent the development of shock and relieve suffering, but does much to keep up the morale of the entire crew.

Only first aid treatment can be given during a naval action; but, because men and material have been well distributed, functioning units can quickly be established in any undamaged part of the ship after action ceases. If the ship is sunk or has to be abandoned because of uncontrollable fires, the survivors are faced with the added hazards of drowning and underwater explosions. Rescue of these survivors cannot be accomplished by the larger ships because of the constant danger of torpedoes, and must be done largely by destroyers, whose small size, greater maneuverability and speed, make them less vulnerable as well as less valuable targets.

Meager facilities are available on such ships for the care of large numbers of casualties, but their speed reduces the period of evacuation of the survivors to a minimum.

The advance base hospitals, while well equipped for all definitive surgical treatment, cannot allow themselves to become overcrowded with those whose convalescence will necessarily be prolonged. Base and convalescent hospitals, are established remote from the active combat area, where those whose restoration to combat duty is anticipated within a period of 3 months, can recuperate in safety and relative comfort. Ordinarily those whose convalescence is likely to exceed 3 months, and those whose ultimate restoration to combat or sea duty is problematical, are returned to hospitals in the Continental United States for disposition. Here in both general and specialized hospitals many can ultimately be restored either to a full duty status or to limited duty ashore.

Those whose physical condition prevents their return to any useful duty are now being given special training through a rehabilitation program, recently established, to enable them to take their places as useful citizens in civil life.

To recapitulate then, the general plan of handling casualties consists of:

1. Immediate first aid treatment, including the use of sulfonamides, both locally and systemically.

2. The early administration of plasma in combating shock and the early application of splints to facilitate transportation.

3. Provision, as near the combat area as possible, of adequate surgical facilities for handling such urgent cases as abdominal and thoracic injuries.

4. Early and rapid evacuation of all casualties that can be moved (preferably by air) to well equipped and adequately staffed hospitals and hospital ships well out of the zone of combat.

5. Expeditious evacuation of wounded whose restoration to duty is likely to be prolonged, to base and convalescent hospitals still further removed from the combat areas.

6. Transfer to hospitals in the Continental U. S. of all whose ultimate restoration to combat duty is questionable.

Having covered briefly the general plan for handling battle casualties, let us take up more specifically the treatment of certain types of injuries.

Burns are more frequently encountered in Naval engagements than in land battles. Their treatment has undergone more radical changes, perhaps, than almost any other type of injury. Reasons for the high percentage of burns in Naval warfare are not hard to find. The compartmentation of ships confines the blasts from explosives and directs these blasts down passageways instead of allowing them to dissipate in the air. Furthermore the presence of fuel oil, explosives and (particularly on aircraft carriers) gasoline, makes fire almost inevitable; and fires at sea are difficult to control and hard to get away from. However, with better damage control, improved fire fighting equipment and removal of all possible inflammable material from fighting ships this danger has been minimized. Furthermore, since the bitter lessons of Pearl Harbor, we have learned the protective value of even a thin shirt against flash burns, and with the universal use of flash protective clothing these burns are now less serious and less frequently encountered than we were led to anticipate by that experience. In the treatment of burns, the primary consideration is the treatment of shock and replacement of body fluids by the use of blood plasma intravenously. As plasma is replaced further loss of plasma from the burned areas must be checked. While the use of tannic acid or other escharotics is effective in checking plasma loss, experience has shown that burns treated in this way under battle conditions invariably become infected. This method of local treatment has now been discarded in favor of simple ointments, applied under bulky dressings, with pressure bandages to control oozing and edema. Preliminary debriding of burns has resolved itself into a very gentle cleansing with white soap and soft cotton pledgets, followed by sterile water or saline.

Fuel oil is better removed with mineral oil than with any of the newly developed detergents which have been advocated for this purpose. Sulfonamide preparations, either combined with the ointment or dusted on as a powder, are being widely used in the local treatment of burns. Plain vaseline gauze makes the

best dressing, particularly in the tropics where ointments break down in the heat, and it is my personal opinion that the systemic administration of sulfonamides supplies an adequate concentration of the drug without danger of overdosage from absorption. Dressings are applied and allowed to remain for 10 to 14 days unless indications of infection call for their removal and substitution with wet dressings. Most burns treated in this way will be healed or ready for skin grafting in 2 weeks.

Chest wounds probably account for a large percent of those who are killed in battle and for whom no treatment can avail. Those who survive are given priority in evacuation from the combat zone where little can be done for them other than prepare them for travel by the preliminary use of sulfonamides and plasma. Sucking wounds are sealed with occlusive dressings, with vaseline gauze over the wound. Morphine is used with caution because of possible respiratory embarrassment. Evacuation by air is safe only at low altitudes. Even with adequate hospital facilities available, the best results are being obtained by conservative treatment. Debridement is not carried out radically, but only superficial foreign bodies are removed, only wounds of the pleura are closed, and attention is directed toward maintaining the normal relationship of intrathoracic organs.

Abdominal wounds are second only to chest wounds in priority. Where intestinal perforations have occurred early surgery is required and few of these cases survive who do not have the benefit of this surgery within 6 or 8 hours, and consequently few reach the base hospitals without having been operated on at sea or in field hospitals within the combat area.

In connection with chest and abdominal injuries is the interesting problem of blast injuries. Air blasts from bombs or exploding shells may cause profound shock and sudden death without external evidence of injury. The pathology produced seems to be largely confined to the lungs where pulmonary hemorrhage and edema take place. Therapy indicated is the treatment of shock and administration of oxygen. Underwater blasts produce more serious injuries, usually to the abdominal viscera, but also to the lungs. Injury to abdominal viscera seems to be determined by the presence of gas or air. Solid organs are not affected but hemorrhage and perforations occur throughout the intestinal tract. Those with perforations need early surgery but due to the circumstances under which most of these injuries are incurred, few are fortunate enough to get it. Many survivors have recovered under conservative therapy and although they have shown signs of extreme pain, tenderness and rigidity, suggestive of intestinal perforation, their lesions have probably been confined to multiple hemorrhages. A remarkable degree of protection against immersion blast injuries is afforded by the wearing of Kapok lifejackets which cover the chest and abdomen.

Head injuries are treated conservatively in the combat areas with little more than local sulfanilamides and pressure dressing. Experience has shown that they stand transportation better before extensive surgical treatment than after it, so that better results are obtained if they are evacuated to a base where convalescence will not be interrupted, prior to definitive surgical treatment.

Injuries to the extremities constitute a large proportion of the casualties we see. These, of course, vary in degree from small, clean penetrating wounds, involving only soft tissue, to severe compound fractures complicated by many foreign bodies. Among these cases we have seen practically no tetanus and very little gas gangrene. The fact that all men have been actively immunized with tetanus toxoid and practically all wounded receive a booster dose of the same toxoid, as well as both local and systemic chemotherapy, is undoubtedly a large factor. However, it must be remembered that all our Pacific casualties have occurred on board ships or on the virgin soil of the Pacific Islands, and the fighting now going on in Europe may result in a different picture. Methods of treating these injuries vary greatly with the circumstances, the facilities at hand, and the individual surgeon. However, certain trends are noticeable and worthy of comment. Radical debridement is being supplanted by conservation of tissues. Results seem to indicate that a ruthless sacrifice of tissue and a meticulous trimming until red, bleeding contractile tissue is reached, is not only a waste of surgical energy, but is not always in the best interests of the patient.

Continued on page 29

According To Their Lights
M. G. H. — O. S.

Annual Oration — Portland Medical Club
December 5, 1944

By Walter E. Tobie, M. D.

Most of you will think of Dr. Charles O. Hunt as Charlie Hunt's father, if you think of him at all, but he was a man of note in medical circles for a long time, was Professor of Materia Medica in Bowdoin Medical School, and Superintendent of the Maine General Hospital for twenty-eight years. Dr. Hunt was born in 1839, was a Lieutenant in the Fifth Maine Battery in the Civil War, a graduate of Bowdoin College in 1861, a graduate of medicine from the University of Pennsylvania in 1868, and a practicing physician in Gorham and Portland for a time.

As a practising physician he was not a marked success, financially at least, and he welcomed the opportunity to become Superintendent of the Maine General Hospital because it gave him an assured living. He continued as Superintendent until 1902, at which time he was sixty-three years old, but looked and appeared rather older. I remember him best in 1899 and 1900, and I think at this time that both Dr. Hunt and the hospital had become somewhat static, although both had had their troubles in the earlier days.

Dr. Hunt was anything but a demonstrative man and would perhaps hardly have been called genial, but for some reason he took a fancy to me and I came to know him very well, and liked him much. To describe him briefly, I will say that he was a man of high character, scrupulously honest, somewhat religious and very methodical. The outstanding traits that seemed to impress most of the doctors who had to deal with him were his thrift and frugality. They were even disposed to consider him, as he himself once confided to me, picayunish. Whether this was a natural trait or something that he had acquired as Superintendent of the hospital I am not prepared to say—both perhaps.

He looked upon his office as a sacred trust, believed that the Maine General Hospital was a charitable institution, and strove honestly to make the small amount of money at his disposal go as far as possible. There was one striking inconsistency. One of the patients seemed to be a fixture. She was an elderly woman with asthma, arthritis and probably a trace of hysteria. She occupied a private room free of cost and was there many years—twenty-six when she died. Under his gruff exterior Dr. Hunt had a tender heart and he explained that if he turned her out she would be obliged to go to the almshouse. It was before the days of the City Home and Farrington Hospital. It was a most incredible affair nevertheless.

Never in all the years that Dr. Hunt acted as superintendent was there enough money available for hospital purposes and the success that it achieved I think was due largely to his splendid management. The staff members were not always pleased with these evidences of thrift and many of them criticized him; sometimes severely and I think unfairly. He ran the hospital as a man of limited means obliged to keep up appearances might conduct his own private affairs. He watched the expenses very carefully and instituted measures which would appear ridiculous to us at the present time. Some of these measures were perhaps reasonable at their instigation, but they were prolonged long after they were a means of saving money, and even when they had become a marked expense.

One interesting matter in this connection was the water system. Sebago Water was installed in Portland about 1870, at about the time that the hospital was organized. The hospital was built on Arsenal Street and when an arsenal existed there it had a dug well of considerable dimensions which was left on the hospital

grounds, but at the time that I am describing it had been discontinued and perhaps filled up. The hospital was provided with Sebago water, but the company that supplied the water was a private concern and the hospital management, like many citizens of that day, had a feeling that this organization was grasping, unfair and extortionate, and so there were drilled in Portland a number of wells many hundred feet deep. They were commonly called Artesian wells. In the interest of economy and to avoid paying an unjust tribute to the Portland Water Company the Maine General had such a well drilled 830 feet deep. It was back of the main building, but as additions were made it came to be covered by a part of the engine room, or boiler room. The water from this well was received into a tank in the basement and from there was pumped to another tank high up in the building, and thence conducted by gravity to the different parts of the hospital. It was interchangeable with the city water, and it was figured that a large sum of money was saved each year, and in addition perhaps that it was a fitting rebuke to the grasping and mercenary organization that sold the water.

It was the practice to economize in the use of medicines and some things were bought in large quantities — carbolic acid for instance in five-gallon carboys—to get the wholesale price. The drug room where drugs and galenicals were stored and dispensed was directly over the water tank in the cellar, and in an evil moment one of the house doctors was manipulating this large carboy of carbolic acid, and spilt a considerable amount of it on the drug room floor. It seeped down into the tank below and residents of the hospital, patients and others, began to detect the subtle odor and taste of phenol, as it is called now, in their drinking water. An investigation disclosed quite readily the way in which this delicate flavor had been imparted and for a time water from the "drilled well" was shut off and Sebago took its place, regardless of cost. As a matter of fact, I think it is doubtful if anything was saved by this elaborate and expensive method of securing water, but it was felt that it was in the interest of economy and so it was continued more or less for a number of years.

The Portland Water Company passed out of existence and was succeeded by the Portland Water District, supposed to be liberal and kindly disposed, although there were those who never noticed any marked difference in their water bills. For many years the piston played up and down in this cylinder through Bramhall Hill and beneath it, until one day it broke off. It was discovered that the expense of getting the piston out would be very great indeed, out of all reason, and Dr. Charles D. Smith, who was successor to Dr. Charles O. Hunt, and in many respects the same kind of a man, was reluctantly obliged to discontinue the use of this well and run the hospital with Portland's greatest asset, "Pure Sebago Water" as the advertisements have it. It was the sad end of a noble experiment.

Another marked economy was in the lighting, which was primarily done by electricity. The early arc light system had passed out and incandescent lights were in use. The regular bulb was sixteen watt and the extra large thirty-two. During the daytime electric lights were not used to any marked extent. The operating was done principally under natural light secured through large windows and skylights. It was believed that a large amount of money could be saved by instituting a private lighting system and this idea was probably encouraged by the manufacturers who had this expensive equipment for sale. In the interest of economy, the generating dynamos were shut off at eleven o'clock at night and from that time until morning kerosene lamps were used in the wards. The illumination certainly was not brilliant, but it was believed that night was the time for sleep and so these lamps were lit when needed and carried to the bedsides of the patients. Fancy if you can the difficulties that beset a nurse trying, let us say, to catheterize a patient by the aid of a kerosene lamp of the pedestal variety, possibly steadied by another nurse but frequently braced up in some way on the bed. Why these lamps did not upset and set the place on fire I never knew for they used them in a happy, light-hearted manner—at least it was light-hearted—and one nurse by the way at night was supposed to care for a ward of twenty-five patients, remaining on duty from seven in the evening until seven in the morning.

In the event of an emergency operation com-

ing in at night, a complicated series of procedures took place. The night superintendent, who was an undergraduate nurse, notified the house doctor, the house doctor telephoned the adjunct surgeon, who came up in a half hour or an hour, and in the meantime the night superintendent had notified the night watchman, and the night watchman, if he was skilled, started the engines and dynamos going, but if he lacked this skill he called to his aide from an adjoining street, Mr. George Gray, who was the engineer and general factotum, and who had assumed the title of Chief Engineer. He was the first chief we ever had. Sometimes Mr. Gray was at home, but if he chanced to be playing cards at the West End Hotel or the West End Engine House he could still be reached by telephone. Once he arrived the machinery was put in motion, the engines were started, they connected with the dynamos, the dynamos generated electricity, and lights began to flash in the operating room. The elevator worked by means of a water pump and this water pump was set in motion by impulses from the engine room. Now the stage was fairly set for the operation. It took some little time but I am bound to say that everybody involved, doctors, nurses and mechanics worked rapidly and the operation was started in a fairly short time, everything considered. It was certainly a complicated series of maneuvers and quite dependent on the engine room. I do not remember how long this system of lighting prevailed. It was, of course, an advantage to have an independent lighting system, for as we all know, when the wires are blocked at Bonny Eagle, we are likely to be deprived of lights. To this extent it was good. I cannot recommend the system of kerosene lamps after eleven o'clock, or the necessity of walking one, two or three long flights of stairs in the darkness for lack of elevator service, and a sixteen or thirty-two watt lamp would seem mild at the present time.

The chief engineer, George Gray, was a conspicuous member of the hospital personnel. He was a burly fellow, rude but reputable. He had an intimate knowledge of the machinery of the hospital, knew all about the intricate mechanism, and kept it for the most part concealed in his manly chest, or somewhere. It gave him a hold on the institution and made him an important cog which he appreciated much. He was not a shrinking violet, but allowed his light to shine and gloried in it. At one time he conceived the idea of having stationery printed for the hospital with a cut of the building in the upper left hand corner. The space at the upper right hand corner he kindly and modestly reserved for Dr. Hunt's picture, but Dr. Hunt would have none of it and, I am sorry to say, turned him down rather forcibly. Mr. Gray then banished all diffidence and had a lithograph made of his own gothic features, had the stationery printed and distributed it to nurses and doctors at his own expense. On the left the caption read The Maine General Hospital; on the right, George Gray, Chief Engineer. Dr. Charles O. Hunt snorted but was obliged to swallow it.

The X-ray department was in its infancy at this time. The hospital steward was Evander P. Getchell, who presided over the culinary department, and outlined the meals which were cooked by a colored man named George English. Mr. Getchell was a man of great intelligence and remarkable ability. He took up the study of X-ray and, self-taught, became not only an accomplished X-ray technician but a finished radiographer, in the opinion of the staff of that time. The work he did was of a very high order and other than X-ray treatment he met all the staff requirements for many years. There came a time when Mr. Getchell was, as the expression is, eased out, and he equipped an X-ray establishment of his own which flourished for many years until sickness and age prompted its discontinuance. Our early X-rays were of a simple character, taken in one dimension usually, and involving bones and bullets.

The Superintendent of Nurses was Miss Amelia L. Smith. She was a tall woman in her middle or late forties, and I can dispose of her virtues very briefly by stating that she had marked ability, conducted a good training school and graduated nurses who were perfectly splendid. On the other side, to state things as they were, I am sorry to say that she was stern, rigid and unyielding. She was dominant and domineering, hard, often unkind in her treatment of the nurses, and frequently cruel. When I look back I am surprised that

she succeeded as well as she did, but explain it on the assumption that her graduates were not supposed to be educated nurses but trained nurses — a descriptive title that the nursing body seems to have taken to itself. Perhaps training is best carried out by harshness and intimidation. They train horses and dogs that way, although idealists are disposed to mention in this connection kindness, affection and love. Miss Smith had complete authority over the student nurses and ruled them with a rod of iron. Her authority and influence did not extend beyond the day of graduation, or beyond the hour. Once they received their diplomas they were free women and acted accordingly, usually making a quick get away.

Miss Smith's authority, while absolute as regards the nurses, did not extend beyond, and this was to her a matter of deep grief. The house-maids were in charge of a matron. She certainly could not order the members of the staff about, much as she wanted to, and she had no authority over the house doctors. She sometimes made it uncomfortable for them by referring matters to Dr. Charles O. Hunt, who in turn, I am sorry to say, sometimes yielded to her requests and bore down heavily on the house doctors. They were fairly bright young men, even though I was one of them, and they knew when this took place and by means as devious as those she employed and much more subtle, frequently rendered these adverse rulings null and void. I think at the end of the year the score was at least balanced, with perhaps a little something plus on the side of the doctors.

There was practically nothing in the way of social life for the nurses in training and the graduation exercises, if I may call them that, consisted in handing out a diploma, frequently with an acidulous look. If there was a nurse whom the Superintendent disliked but felt obliged to graduate on the findings, she would leave this function to the assistant superintendent who, by the way, was not a graduate nurse but a member of the senior class, selected sometimes for her ability, sometimes through the art with which she had charmed the superintendent, and sometimes from her place of residence, favoring those who came from her own town or nearby. There was one nurse who had never been in her favor but who had no considerable number of errors scored up against her and appeared to have committed no indiscretion. The exercises went on in this way. The nurse went to the office to receive her diploma. Miss Smith held the diploma in her hand, a real parchment diploma and not a dummy, and said, "Now, Miss Laughlin, I have your diploma here but you are not going to receive it. It is made out to Katharyn Laughlin and I have discovered that you have recently married so that your name is no longer Katharyn Laughlin." "Oh, yes it is, Miss Smith. I married my cousin, William Laughlin, and my name is still Katharyn Laughlin." Before Miss Smith could recover from her surprise, Katharyn reached out and grabbed the diploma, left the room in some haste and came not back again.

Most of them never came back. All the nursing was done by undergraduates. The Superintendent of Nurses wore the only white uniform and *gloried* in the distinction. Her ideal was Florence Nightingale, and if we accept the debunked biography of this great woman, she hit it pretty well.

Graduate nurses were not in favor. They were not permitted to nurse private cases in the hospital. In the year that I am describing there was but one exception, an elderly nurse who was permitted to come in with the wife of a director or a member of the Ladies' Advisory Board, an organization of some influence in this early day. This venerable nurse did not receive a real warm welcome and looked and acted ill at ease.

The nursing of the undergraduates was of a very high order. In a year's time a nurse was good if she was ever going to be, and it was the senior nurses who were put on private cases. It was considered something of an honor and an integral part of a nurse's training. Most of the nurses were placed in charge of a ward for a time at least, and all of them were taught anesthesia and permitted to etherize a certain number of operative cases. This, I think, was the poorest work they did. The ability to give ether is something of a gift, which all of them did not have. In addition, it may be stated that this was probably the poorest instruction they received, due somewhat to the fact that those

who were assigned to teach this branch were not themselves wonderfully well qualified.

The training course was two years, the nurses' hours of work were from seven to seven, either day or night, and they not infrequently exceeded the regular number of working hours. They had very little time off. It was an intensive course but gave splendid results. I do not believe that any of them broke down from overwork or nerve strain. After graduation, their work was outside in private homes. They appeared to be ready to go anywhere at any time and generally had plenty of work. They charged eighteen or twenty-one dollars a week, depending on the character of the case or the ability of the patient to pay. These rates were apparently adopted by a tacit agreement, and there was nothing in the nature of a union schedule regulating them. No obstetric work was done in the hospital, so the students had no experience in this important branch. Neither were the graduate nurses employed in obstetric cases to any considerable extent, partly because they had had no experience in this kind of work, partly perhaps on account of the expense, but largely on account of habit and custom which had ordained that this work should be in the hands of a middle-aged or elderly practical nurse, who did more than simply care for the patient or patients. This was forty-five years ago. Ten of the graduating class of fourteen are married, four have died, and I think there is one still doing some kind of nursing work.

The Maine General Staff of this time left practically nothing to be desired. There were four surgeons who bore the title of Attending Surgeon, four Adjunct Surgeons, four medical men, or Attending Physicians, two Eye and Ear men and one Nose and Throat man. Surgeons did by far the largest amount of work. Medical cases did not come to the hospital in any considerable numbers. The whole conception of the hospital was that of a charity. The men took hospital positions, it is true, in order to gain practice and prestige, but they did not continue active hospital work after it had become burdensome to them, and with a single notable and unfortunate exception, no man remained on the surgical staff after he tired of doing the routine work. As a result of this attitude there were frequent opportunities for young and energetic men to enter the field of surgery as adjunct surgeons. The surgeons gave up their free hospital service long before they were obliged to; long before they were on life's Western slope. Two men of that day became full surgeons at about thirty, held the positions a few years, and then resigned and practised private surgery for many years. An age limit was entirely unnecessary.

Men on the retired staff furnished a large number of the private patients, who were a source of income to the hospital. The attitude of the men of that day was professional and ethical in the extreme. They made no complaint at the burden of free service; no criticism of the patients presented to them for operation. A great many people of some means took advantage of the low hospital rates and secured the service of master surgeons without paying an operating fee. It was not until some years later that the feeling against this crept in, and at the time I am describing, I am sure that no one made any effort to profit from the patients. I think also that they all gave their best work to every patient.

As far as possible there was rotation in the terms of service in order that people could not altogether take advantage of the free operating and secure their own preferred surgeon without charge. The surgeons each served a term of three months and the adjuncts were assigned to them in such a way that they did not have the same adjunct continuously or twice in succession. This overcame the chances of favoritism which might naturally occur with both surgeons and adjuncts, and gave each adjunct a chance to get experience and training with every surgeon.

The operating was done in the morning, generally starting at ten or ten-thirty. The attending staff members, surgeons and medical men, all practiced general medicine. They would drive about, make their morning calls, and appear at the hospital in the middle of the forenoon. In the summer time they secured their horses to hitching posts in front of the hospital on Arsenal Street, and in the winter put them in a horse shed which was back of the hospital, a place now occupied by some of the hospital buildings. The operations were continued until

they had completed the assigned work. Sometimes they got through by twelve or one, but not infrequently worked continuously until four or five, regardless of what outside work they might have waiting. The surgeons were privileged to turn some operations over to the adjuncts but the serious, major cases they were supposed to do themselves and did. A man could not retain his position and have another man do his work. If they had time, they made their hospital rounds before the operations; if not, after they had finished, and they were quite particular to see every patient.

The patients stayed in the hospital three or four weeks; appendix cases were kept in bed eighteen or twenty-one days. Ward patients paid $1.25 a day. Small rooms adjoining the wards, called ward rooms, were $2.50 a day, and the large private rooms were $5.00 and $6.00 a day, and this included the services of a special nurse for the entire twenty-four hours. She was a senior student nurse, and as far as I could see then, or as far as I have been able to see since, she was the equal of any graduate nurse of that day or this. Some modern refinements she did not know; neither did the doctors. She did not take blood pressure; neither did the doctors. She did not give infusions and neither did the doctors. In the actual care of the sick, which is primarily the function of a nurse, she was perfectly good. She had a few hours off in the day for sleep and undoubtedly got some rest at night. A bed or cot was provided for this purpose. It was wonderfully efficient, perfectly satisfactory, and certainly a great bargain in surgery and nursing, if I may express it that way.

The food of the private room patients was of a superior quality, abundant in amount and great in variety. The ward patients did not fare as well. They were charity patients to a great extent and probably many of them were better fed than they would have been outside. The food was plain and wholesome, of a sufficient amount, but monotonous as regards variety. The wards were kept scrupulously clean, the mattresses and bedding were perfectly good and adequate, but the general appearance was rather plain.

The Department of Pathology was certainly in its infancy. The pathologist was Dr. Edward J. McDonough, and Mac took this position because it was like being a policeman in New York, it led to something better. It was a stepping stone to a position on the medical staff which he secured a few years later. Mac was probably as well qualified for this position as anyone in the City of Portland at that time and had studied in Boston under Mallory and Wright. He practiced general medicine, but at heart was an obstetrician and eventually worked into that kind of practice.

The pathological room was on the second floor of the old amphitheater. It was most completely devoid of all equipment; no microscope, no microtome, no centrifuge. The shelves were lined with gross specimens in bottles and jars dating back to the beginning of the hospital. Most of the important work that Dr. McDonough did was done outside and the house doctors analyzed the urine. The sink was generally filled with half-filled bottles of urine. There was no provision for caring for this room, and apparently no one to clean it up, so it was not cleaned.

In the basement, quite near the elevator, was a room called the "dead room," eschewing such fancy names as morgue, mortuary, post-mortem room or autopsy room. Autopsies were very infrequently performed. Nobody seemed to care much about them. I performed a few, but was sometimes obliged to work at night and do them surreptitiously. If my surgeon had known of my doing them I should have been laid off from the operating room, and if any infection had occurred at any time within a week or two after such an event I would have been blamed. Curious to say, Dr. Charles O. Hunt conspired with me and connived at these events. He said, "You can sterilize afterward, and if sterilization isn't effective, why in the world is it done?"

No smoking was allowed in the hospital and this rule was strictly enforced. Dr. Charles O. Hunt smoked, but he did it in his own home, not in the hospital nor in the corridors. In the rooms and wards smoking was absolutely prohibited. An inveterate smoker admitted as a patient might go three or four weeks without smoking and nothing happened excepting that for the time being he was cured of the habit. When he became convalescent he was permitted

to go to a room in the basement known as the smoking room, but sometimes flippantly referred to as the "Spit Box." It was one of the dirtiest places I have ever seen. It was the only dirty place in the hospital. Men went in there, if they had the courage, sat on hard wooden chairs and smoked pipes and cigars: cigarettes not being much in vogue at that time. I think this smoking room sometimes discouraged convalescents so that after a single visit they refrained from going again, and perhaps were cured of the habit. Let us hope so.

The discipline of the entire hospital was wonderfully good and so was the morale. It was not a particularly happy place, and certainly not a gay place, but it accomplished its purpose and was a credit to the State of Maine and to the men and women who, working for a common cause, did their best according to their lights.

Recent Developments in the Treatment of War Casualties – Continued from page 22

When debridement is done gently, excellent results are obtained in conjunction with the universally accepted use of chemotherapy, the increasing use of plaster immobilization, and the decreasing frequency with which dressings are changed. I have been impressed with the freedom from pain, the absence of fever, the appearance of comfort and the general well-being of men whose casts were softened by the malodorous exudate of severe compound fractures. Very few wounds are being closed by primary suture as most of those that are closed break down. Metallic foreign bodies are being removed only if accompanied by infection, if in or near joints, if they threaten the integrity of an important structure or if they are producing symptoms. Flap amputations are not being done routinely as a primary procedure, but rather guillotine amputations, without regard to elective sites, and as far distally as viable tissue will allow. Thomas splints are used for transportation of fractures in combat areas. They are also used in some base hospitals in conjunction with Kirschner wires and balanced traction, but most fractures are transported and treated in plaster. Some casts are lightly padded but many are not. It is my impression that compound fractures caused by gunshot or shrapnel are usually accompanied by sufficient muscle damage to result in a loss of muscle tone with a resultant lack of spasm. This facilitates reduction and maintenance of position in plaster without the necessity of much traction.

Consideration of recent developments in the treatment of war casualties would be incomplete without some mention of anesthetics. Sodium pentothal has been a boon to the military surgeons. Its lack of bulk, ease of transportation, lack of inflammability, simplicity of administration and rapidity of action and elimination, lend themselves to its military use. While it has its limitations, dangers and disadvantages it is being used with utmost satisfaction and probably to a greater extent than any other one anesthetic agent.

Spinal anesthesia is probably second in its deserved popularity, for almost any type of surgery below the diaphragm. It possesses most of the advantages of Sodium Pentothal except that its field of action is limited. In addition it has a greater margin of safety and produces relaxation so essential in abdominal surgery.

Procaine is probably the safest anesthetic agent we possess, which has all the attributes necessary for military use. Its employment regionally and locally, however, is not as extensive as it might be because too many lack training in and familiarity with its uses.

In summary then we find that there has been a definite improvement in the results we are now obtaining in the treatment of war casualties. The three outstanding factors contributing to these results have been:

1. The development of effective chemotherapy.

2. The production of plasma in a stable form which can be easily transported to and administered in the combat areas.

3. The improvement in facilities, particularly airborne, for transporting the wounded.

All three of these developments are operating to reduce the time factor between injury and definitive treatment.

Editorials

A. M. A. Bureau of Information Now Is Functioning

A Bureau of Information of the American Medical Association to assist returning medical officers of the armed forces in their educational, licensure and placement problems has been created and is now actively functioning in the headquarters of the Association in Chicago, it is announced in the January 6 issue of *The Journal* of the Association.

Outlining the functions and operations of the new Bureau, Lieut. Colonel Harold C. Lueth, Medical Corps, A. U. S., Liaison Officer from the Office of the Surgeon General to the headquarters of the American Medical Association, points out that the specific aims of the Bureau fall into three categories:

"1. To provide veteran medical officers with information concerning educational opportunities immediately after their term of military service.

"2. To provide veteran medical officers with information concerning state licensure and facilitate their procurement of licensure in states other than the state of former practice and/or licensure.

"3. To provide the medical officer with information concerning medical, social, economic, financial and other phases of community life that will enable him to make a wise selection of a permanent location in which to practice medicine."

Regarding the information on medical education, Colonel Lueth explains that through the efforts of the Association's Committee on Postwar Medical Service a questionnaire was prepared to gather as much information as possible from medical officers now on duty concerning their future plans. On the basis of the tabulation of the first 11,019 returned questionnaires, steps already have been taken to assist in providing the educational facilities in approved hospital internships and residences that will be required to meet the needs expressed by the physician veterans in the questionnaires.

Information has been assembled regarding state laws in regard to medical licensure and efforts are being made with a view toward facilitating the licensure of medical officers, many of whom already have made inquiries concerning eligibility for licensure in states other than those in which they were originally licensed to practice medicine.

In regard to information on medical practice, it is pointed out that the Bureau is not a placement agency or an employment agency. It is, however, collecting data that will enable the Bureau to provide inquiring physician veterans a broad outline of pertinent facts concerning the community in which the physician is considering locating. At the same time the inquiring medical officer will be advised that more definite information can be obtained from the secretary or executive secretary of the state medical association.

"The Bureau of Information," Colonel Lueth says, "hopes to work in closest harmony with the various state and county medical societies in their activities relating to the returning medical officers. The success of the Bureau of Information is directly dependent on the support and coöperation of the state and county medical societies. . . . Repeatedly it is said that medicine 'can keep its own house and manage its own affairs.' The successful operation of the Bureau of Information presents a real challenge to all of us to prove our ability to provide for our own."

Senate Subcommittee Issues An Interim Report on Health

The emphasis placed on state planning and control in the field of health by the interim report of the Senate Subcommittee on Wartime Health and Education, which has just been issued, is especially significant, *The Journal of the American Medical Association* for January

6 declares in an editorial. *The Journal* says:

"The Senate Subcommittee on Wartime Health and Education, a subcommittee of the United States Senate Committee on Health and Labor, has just issued its interim report. *The Journal* makes this report available in full in this issue. Attention should be called particularly to the emphasis on the use of government aid in the development of medical facilities where the need can be shown, government aid to medical education, medical research and the development of medical prepayment plans, and government assistance in certain situations in which the needs are clearly apparent for preventive medicine and for general health and planning toward a nationwide network of medical facilities.

"The report makes no specific recommendation in regard to health insurance but does point out that some form of group financing is desirable. It considers voluntary prepayment plans, compulsory sickness insurance, tax supported medical service or various combinations of these methods as technics to be considered.

"Especially significant is the following paragraph from the report, which emphasizes state planning and control:

" 'In order to permit local initiative and control, state programs should be drawn up by state health planning commissions in coöperation with local authorities. In drawing up state plans the commissions should consider the needs of all sections of the state, should include in the plan all suitable existing public and voluntary hospitals, and should plot the new construction as well as the expansion or replacement of existing facilities needed for adequate service. Before federal funds could be granted, however, overall state plans and individual projects should be reviewed and approved by the United States Public Health Service to make sure that they meet certain minimum standards of construction, operation and complete, coordinated service. There should be reasonable assurance that a new facility will have enough patients to justify its existence. In communities where sufficient income from fees of individual patients does not otherwise appear probable, provision for group prepayment plans or tax-supported services, or both, should be required.'

"The report reaches us just as *The Journal* goes to press. The time is too short for detailed consideration of the various aspects of this report. The report, in general, would seem to be a more scientific, carefully considered document than has heretofore been available as a result of previous hearings in this field. The committee emphasizes that its findings are preliminary and that the subcommittee expects to continue its work with further hearings and with studies of the various aspects of the health problem, such as rural, industrial and school health, the health needs of veterans, medical research and medical education."

More Evidence of Penicillin's Value for Subacute Bacterial Endocarditis

Additional evidence that penicillin is of value in the treatment of subacute bacterial endocarditis (bacterial infection of the membranous lining of the heart), a condition which is almost invariably fatal, is reported in *The Journal of the American Medical Association* for January 20 by Martin Henry Dawson, M. D., and Thomas H. Hunter, M. D., New York.

The report concerns the results obtained in the treatment of 20 patients, with a supplemental report on 7 additional patients. Although heparin, an anticoagulant, was used in combination with the penicillin in a majority of the patients, the two investigators obtained some encouraging results without it.

The infecting organism was a streptococcus in all instances. "While it is recognized that a long follow-up will be necessary before the ultimate outcome is established," they say, "therapy [treatment] was apparently successful in 15 of the 20 [patients]. All 15 patients are now clinically and bacteriologically free from infec-

tion. In 2 of the remaining 5 patients the infection was controlled as long as penicillin was administered, but a relapse occurred when therapy was discontinued. These 2 patients are still in excellent general health, and it is hoped that it will yet be possible to arrange for a therapeutic regimen which will produce a satisfactory outcome. The remaining 3 patients succumbed. In each instance death was apparently due to a cerebral embolus [a clot, apparently from the seat of the infection on the endocardium, brought by the blood stream and forced into a smaller blood vessel in the brain so as to obstruct circulation]. In 2 of the fatal cases the infection was still present at the time of death, and in the third the situation was in doubt. Further experience is necessary before an opinion can be expressed regarding the value of heparin as an adjuvant to penicillin in the treatment of this disease."

In an addendum Drs. Dawson and Hunter say that since the preparation of their report 7 additional patients with this disease have been treated with penicillin. In the last 5 of these the drug was administered by the continuous drip method into a muscle and heparin was not used.

"The results indicate that the response was as favorable in this group as in those patients in whom heparin was used," they say. "In 6 patients the infection has apparently been terminated. The seventh patient relapsed after one course and is now receiving additional therapy. . . ."

---

*Mobile X-Ray Equipment to Aid Maine's War Against Tuberculosis**

A tough, slender, wax-like little germ—the tubercle bacillus—which kills 64,000 persons a year in the United States, is the target of a new attack being launched by the State Department of Health and Welfare.

Dr. Roscoe L. Mitchell, State Director of Health, has announced the arrival in Augusta of a new X-ray laboratory on wheels which will make it possible to broaden the front in Maine's war against tuberculosis. This laboratory, known to the medical profession as a photo-roentgen X-ray unit, is the newest weapon developed by medical science for mass chest surveys. It was purchased with state and federal funds.

Mass Surveys Planned

"We plan to use this unit for carrying out our program of tuberculosis control in mass X-ray clinics," said Dr. Mitchell. "These clinics will include high schools, upper grades in the elementary schools, workers in industrial plants, and other groups—the object being to discover cases of pulmonary tuberculosis early when the hope of cure is best."

Because it simplifies and speeds up the process of group examinations, this mobile X-ray equipment, designed and equipped by the General Electric X-ray Corporation, Chicago, is serving health and tuberculosis associations throughout the country. In St. Louis County, Minnesota, for example, the hilly mining town of Ely was visited by the County Tuberculosis Association and each of its 6,000 residents was given a chest X-ray with such a unit. It marked the first time in medical history that every resident of a city underwent chest examination.

"We expect to find five to seven active cases per thousand," said Dr. Mitchell. "Experience has shown that at a permanent clinic we can get only 50 per cent of the cases to come for examination; this is because many people are frightened, uncoöperative, or too busy to submit to X-ray examination. By going to the people with our new mobile X-ray unit we hope to examine 200 to 250 persons a day. If the X-ray film proves negative, the patient will be given the report. If the film is positive, a report will be sent to the family physician, who will contact the patient."

* From Department of Health, State of Maine, Augusta.

Produces 4 x 5 Film

The attractive grey truck, with red lettering, is equipped with a photo-roentgen unit, which produces an X-ray image of the chest on a 4 x 5-inch X-ray film instead of on the conventional 14 x 17 film. The smaller film has high diagnostic accuracy and, in convenience and economy, has distinct advantages over the larger one. For a given amount of money, 10 times as many people can be examined with the smaller film. Also, it is simpler to handle, file, and store for permanent records.

Here is how the X-ray apparatus in the big truck works. In conventional X-ray procedure, the X-rays pass through the patient's chest, throwing the image directly upon a photographic film. The film, usually 14 x 17 inches, must be the size of the chest because it is not possible to focus X-ray by means of lenses. The new photo-roentgen equipment makes use of the customary type of X-ray apparatus to throw the image of the chest on a standard size fluorescent screen. A powerful camera, equipped with an extremely fast lens, is then used to photograph the image on the fluorescent screen. With the aid of this lens the image of the chest is photographed upon a supersensitive film, 4 x 5 inches in size.

Maine's truck is 28½ feet long, 8 feet wide, and 9 feet, 9 inches high, and weighs about 13,000 pounds. It has three dressing rooms, radiographic room, lead-lined darkroom for the developing of X-ray films, and ample cabinet and locker space. The darkroom has a splash-proof developing tank that permits film-processing chemicals to be carried ready for use at any time, wherever the truck stops. A light-tight pass box permits the passing of loaded film holders into and out of the darkroom without opening the door. Lead-lined partitions protect the operator and X-ray technician against stray radiation. The truck is fluorescent lighted, and has four 1,200 watt electric heaters to permit year around use.

Bus Has Many Features

An unusual feature of Maine's unit is the installation of all X-ray and photo-roentgen apparatus in such a fashion that it may be removed from the bus with relative ease and set up in a large school or factory where the number of people to be examined and the time involved would justify this method of conducting a survey.

Other features adding to the efficiency and convenience, as well as to the comfort of both operators and patients, include: padded leatherette seats in each of the three dressing rooms, storage compartments under the dressing room seats; weather-proof ventilators in the roof of the vehicle; raising and lowering safety glass windows, with screens; a small hand sink connected to the 35-gallon water storage tank; seats in the driver's cab to accommodate three persons, and a film hanger drawer to accommodate 19 film hangers.

Army Uses Same Equipment

The same type of X-ray equipment as installed in the Maine ambulatory unit is used by the army to examine the chests of draftees. The army uses the small films for a permanent record to show the individual's chest condition not only at the time of induction, but also at the time of his discharge from service. Thus, it protects the government against unwarranted claims.

The National Tuberculosis Association reports that 12,000,000 X-ray examinations at U. S. Induction Stations by use of the small-film method resulted in 120,000 deferments for chest conditions—10 men in every thousand.

In the post-war period, more of these mobile X-ray laboratories will be provided so that many persons, including those in out-of-the-way regions, may receive the benefit of periodic examination of the lungs by modern X-ray methods.

An elderly man with lung disease is labelled as "chronic bronchitis" by many practitioners. Bronchitis symptoms should receive further diagnosis.—G. N. Meachen, M. D., *Tubercle,* April, 1941.

Tuberculosis is a deep-seated social problem beset with economic and administrative difficulties not encountered in any other disease.—Charles R. Reynolds, M. D., *Bull. Nat'l Tuber. Assn.,* August, 1940.

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Albert W. Moulton, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

100% Paid Membership for 1945
Piscataquis County Medical Society

Hancock

A meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, on January 10, 1945.

Following a short business meeting, Philip L. Gray, M. D., of South Brooksville, read an interesting paper on *Presbyopia.*

James H. Crowe, M. D.,
Secretary.

York

The annual meeting of the York County Medical Society was held at the New Saco House, Saco, Maine, January 10, 1945.

The following Officers were elected for the ensuing year:

President, Harry L. Prescott, M. D., Kennebunkport.

Vice President, Chrysaphes J. Xaphes, M. D., Biddeford.

Secretary-Treasurer, C. W. Kinghorn, M. D., Kittery.

Board of Censors: J. H. Macdonald, M. D., Owen B. Head, M. D., and J. R. LaRochelle, M. D.

Delegates to the 1945 annual session of the Maine Medical Association: W. L. Morse, M. D., Springvale; J. H. Macdonald, M. D., Kennebunk; and Doctor Kinghorn.

Alternates: R. S. Belmont, M. D., Sanford; and Oscar R. Perrault, M. D., Biddeford.

Adrian Scolten, M. D., of Portland, was the speaker of the evening. His subject was *Skin Diseases of Interest to the General Practitioner.*

C. W. Kinghorn, M. D.,
Secretary.

Pay Your 1945 State and County Dues to Your County Secretary

Necrologies

George I. Geer, M. D., 1884-1945

George I. Geer, M. D., 60, died at his home in Portland, Maine, January 19, 1945.

He was born in Westbrook, Maine, July 9, 1884, the son of George L. and Katie A. Geer. He was graduated from Westbrook High School and received his medical degree from the Maine Medical School in 1908.

Doctor Geer was a member of the Cumberland County Medical Association, the Maine Medical Association, and the American Medical Association. He was a member of the staff of the Mercy Hospital, and was Senior Medical Examiner for the Metropolitan Life Insurance Company.

Surviving besides his widow, Mrs. Jennie Merrill Geer, are three sons serving with the U. S. Army. Dr. George Geer, Jr., a captain; Dr. Charles Geer, a lieutenant in the Medical Corps; and Merrill Geer, in the Air Corps; and three daughters, Martha, Catherine and Muriel, all graduate nurses.

Walter F. W. Hay, M. D., 1897-1944

Walter F. W. Hay, M. D., 47, surgeon, obstetrician and gynecologist, died suddenly in his office at Portland, Maine, December 27, 1944.

He was born at Tangier, N. S., February 1, 1897, son of Ex-Mayor Harry F. G. Hay of Westbrook, and the late Grace Shatford Hay, and came to Portland with his parents in 1900. He was graduated from Westbrook High School in 1916, Bowdoin College in 1920, and Harvard Medical School in 1924. During World War I he served overseas with the Red Cross Ambulance Service.

He interned at the Boston City Hospital and the Boston Lying-In Hospital, and served on the surgical staff of the former hospital. He was with the pathological departments of the Boston City Hospital, Harvard Medical School, Peter Bent Brigham Hospital, and the Massachusetts General Hospital before beginning practice here in Portland in 1927.

Doctor Hay was a member of the Portland Medical Club, the Cumberland County Medical Association, the Maine Medical Association, the American Medical Association, the New England Society of Surgeons and the New England Society of Obstetricians and Gynecologists, and in 1931 was elected a Fellow of the American College of Physicians and Surgeons. He was on the staff of the Maine General and Children's Hospitals, and was visiting surgeon at the Mercy Hospital and the Maine Eye and Ear Infirmary.

Surviving besides his father are his widow, Mrs. Alice White Hay; four sons, MT/Sgt. Walter F. G. Hay, Jr., USMC; Pvt. R. Channing Hay, USMC; John A. Hay and H. Graham Hay; two sisters, Miss Cora G. Hay, Westbrook; and Mrs. Fenwick L. Leavitt, Barre, Vermont; and a brother, John W. Hay, Westbrook.

Notice

Governor Horace A. Hildreth Names Medical Examiners

Governor Hildreth has named the following medical examiners for four-year terms each:

Androscoggin County: Drs. R. A. Beliveau, Lewiston; and H. S. Pratt, Livermore Falls.

Aroostook County: Drs. Francis Faucher, Grand Isle; Frank H. Jackson, Houlton; and Herrick C. Kimball, Fort Fairfield.

Cumberland County: Drs. J. M. Bishoffberger, Naples; Ervin A. Center, Standish; and William Holt, Portland.

Franklin County: Dr. George L. Pratt, Farmington.

Hancock County: Drs. Charles C. Knowlton, Ellsworth; George A. Gregory, Boothbay Harbor; and Joseph E. Odiorne, Whitefield.

Kennebec County: Drs. Roland L. McKay, Augusta; L. D. Herring, Winthrop; John G. Towne, Waterville; and Clarence McLaughlin, Gardiner.

Oxford County: Drs. Kenneth E. Dore, Fryeburg; John A. Greene, Rumford; and D. M. Stewart, South Paris.

Penobscot County: Drs. Herbert C. Scribner, Bangor; Cornelius J. Taylor, Bangor; H. Lewis Taylor, Dexter; G. Frank Woodbury, Patten; and E. T. Young, Millinocket.

Piscataquis County: Dr. Albert M. Carde, Milo.

Sagadahoc County: Dr. Edwin F. Pratt, Richmond.

Somerset County: Dr. W. S. Stinchfield, Skowhegan.

Waldo County: Drs. E. P. Goodrich, Winterport; and Orris S. Vickery, Belfast.

Washington County: Drs. James C. Bates, Calais; and Oscar F. Larson, Machias.

York County: Drs. George R. Love, Saco; J. H. Macdonald, Kennebunk; and Paul Taylor, Kittery.

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, March, 1945 No. 3

*Professional Service Accounting**

By T. R. Ponton, M. D., Editor, *Hospital Management*

When the state licenses a physician to practice medicine it issues a blanket permit which authorizes the licensee to treat all types of disease in any patient who may present himself. Legally, the state does not and cannot differentiate between the young and inexperienced physician who has recently graduated and the physician who has supplemented his theoretical knowledge by long years of experience; nor have any means been found whereby the older physician who has allowed himself to deteriorate professionally may be differentiated, under licensing laws, from the man who has become increasingly competent as the lapse of time has afforded opportunities for increasing his knowledge and skill in the art and science of medicine.

The members of the medical profession have long seen this defect in all systems of licensure and many attempts have been made to find a remedy but, up to the present time, no means have been found whereby the license of the physician may conform to his known competence. In the hospital there is, however, the possibility of legally controlling the practice of the members of the medical staff. Numerous court decisions have established both the right and the duty of the governing body to select the medical staff with due care and to enact such reasonable rules and regulations as may be advisable for the government of the conduct of its members.

Recognizing this power of the governing body to control the work in hospitals, the surgeons of the United States initiated a movement whereby those appointed to the various divisions of the surgical staff would be allowed privileges in conformity with known competence, but there was great difficulty in finding means whereby the degree of skill could be determined with justice. Reputation was acquired, all to often, without regard to actual competence. Observation was unsystematized and opinions based on observation were little better than those resulting from reputation. Preceptorship necessitated the preceptor to pass judgment on a fellow practitioner and he had no basis for his judgment except his own opinion, which was so often prejudiced by the fact that the physician on whom he was asked to give an opinion was a potential business rival.

For many years the death rate was used as a measure of competence, but a little thought will show the fallacy of such a basis of evaluation.

* Read at the annual meeting of the Maine Hospital Association, Waterville, Maine, June 23, 1944.

One physician may treat a large proportion of serious cases and, as a consequence, may show a high death rate, while a second, all of whose cases may have only a mild threat to life, may show a low death rate. Yet the first physician may be the more competent of the two.

All these facts became apparent to the writer almost immediately after he entered the field of hospital administration, and means were sought whereby there could be judgment based on recorded evidence of the quality of the work of the individual members of the medical staff. The result was a system of Professional Service Accounting which had been developed sufficiently to allow presentation of a preliminary report at the annual convocation of the American College of Surgeons, held in Boston in 1928. Since that time steady progress has been made in the development of the system.

Professional Service Accounting has the basic idea of making a comparison of the results actually attained in the treatment of a patient with those results which might reasonably be expected from the prognosis, the comparison being made from recorded data. This is the only fair basis of evaluation, but it has certain limitations which must be recognized.

First of these is the necessity for a complete and accurate case study which will give a true picture of the patient in his illness. It need not be the formal record so often seen, but it must show a study of the pathology of the patient, his ability to resist that pathology, the means taken to help nature in combating the pathology and the results attained. As yet we are far from securing such records.

The second limitation lies in the fact that there is no exact measure of evaluation such as the monetary system used in business accounting. Of necessity there can be only an appraisal of the quality of the work, and in making this appraisal it is impossible entirely to eliminate the personal equation as found in the patient, the physician who treats him and the appraiser. By taking proper precautions, however, the effect of this personal equation can be so controlled as to be almost negligible.

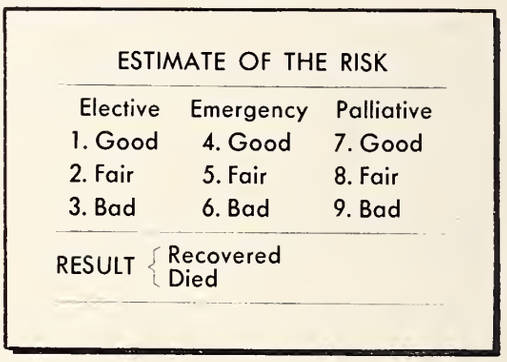
A third limitation lies in the fact that, at present, it is possible to compare only the immediate results with the prognosis; yet in many cases it is necessary to know end results if a proper appraisal is to be made.

If these limitations are kept in mind and if the absolute accuracy of financial accounting is not expected, the system can be made to give information that will be of inestimable value to the patient, the physician and the hospital.

The System

All patients enter hospitals for treatment which is elective, emergency or palliative. (Fig. 1.) Elective treatment is undertaken voluntarily on the part of both the patient and the physician, and there is expectation of cure. Emergency treatment is that which must be given at once, and effort is directed solely to the saving of life. Palliative treatment, like elective, is voluntary, but there is no expectation of cure. The effort is to prolong life or to lessen disability.

Figure 1



In each of these three classes the risk is good, fair or bad. There are thus given nine prognostic categories into one of which the physician is required to place his patient as soon as he has made sufficient study to warrant judgment. It should be possible to state this estimate in every case before treatment is undertaken.

In order to secure a carefully considered estimate of the risk the physician is required to state his reasons, should he class the risk as fair or bad or should he subsequently desire to change his prognosis.

When the patient is discharged the result is stated as recovered or died.

It is necessary that convenient means be provided whereby the physician may record this data. It may be on the statistics card, on the summary sheet or in any other part of the record that may be found convenient. The essential is that it be placed always in the same part of the record and that it be easily accessible to the physician.

In order that there may be accuracy in making this statement of comparison and to make the greatest possible use of the information supplied by Professional Service Accounting, a Professional Service Accountant is appointed. He may be a member of the medical staff or an outside physician selected for the purpose. His duties are:

1. To check the statement of prognosis and results. If he agrees with the statement of the physician he will approve the record for indexing. If he disagrees he will:

(a) Make the necessary change on his own authority;

(b) Confer with the attending physician and arrive at a decision, or

(c) Refer cases in which a decision cannot be reached to the auditing committee.

2. To decide whether the case is major or minor. (Some hospitals use an additional classification of *intermediate*.)

The generally accepted definitions of these classes are as follows:

(a) *Major:* When, for any reason, there is a serious hazard to the life of the patient.

(b) *Intermediate* (when used): When, for any reason, there is not a serious hazard to the life of the patient but there is danger of disability.

(c) *Minor:* When, for any reason, there is neither serious hazard to the life of the patient nor is there danger of disability.

3. To decide whether or not the result is that which should be expected from the prognosis.

4. To detect possible errors in diagnosis, treatment, judgment or technique.

No professional service accountant can be so well versed in all specialties as to warrant judgment in all cases, and an auditing committee representing all the specialties should be appointed to supplement his judgment. The duties of this committee are:

1. To arrive at a decision in cases referred by the professional service accountant;

2. To decide whether or not there has been an error;

3. To refer cases in which staff action is indicated, or which may have an educational value, to the full staff.

The data thus secured is transmitted to the medical records librarian who will enter it in the Physicians' Index (Fig. 2), thereby com-

FIGURE 2

Service Code
A Medicine F Dermatology K Urology
B Surgery G Communicoble L Orthopedics
C Gynecology H Pediotrics M Neoplosms
D Obstetrics I Miscelloneous N Troumotic
E Eye, Ear, Nose ond Throot

PHYSICIANS' INDEX

Doctor Nemo

Division Active Service Surgery

Hospitol Number	Major	Intermediate	Minor	Service	1 R	1 D	2 R	2 D	3 R	3 D	4 R	4 D	5 R	5 D	6 R	6 D	7 R	7 D	8 R	8 D	9 R	9 D	Incomplete record	Results: Favorable	Results: Inevitable	Results: Justifiable	Notes
83	1			B	1																			1			
346	1			B	1																			1			Goitre, no B.M. recorded
370	1			N												1										1	Fracture femur, age 76
546	1			N												1										1	Traumatic shock
489	1			B							1												1				Secondary hemorrhage
288	1			B			1																1				General peritonitis, cause unknown
178	1			B	1																			1			Ac. appendicitis, in hosp 24 hours before operation, no blood count
519	1			B												1										1	Ruptured peptic ulcer, operation refused at former admission
485	1			B			1																			1	Cholecystitis, posterior coronary
772		1		C	1																					1	
921	1			M																	1					1	Carcinoma pylorus, obstruction
																											(Others not shown)
Totals	87	9	6	89	241			4	6	2	9		3			7	8		6		10	4	12	25	8	2	10

piling a permanent record of the work of each member of the medical staff.

Formerly it was recommended that errors be made a permanent part of this index, but the index could be subpoenaed and used as evidence against the physician in case of a suit for malpractice. It is therefore recommended that no permanent record of errors be kept. This does not mean, however, that errors are to be ignored. Action designed to prevent their repetition should be taken by either the auditing committee or the full medical staff, depending on which can most effectively prevent repetitions, after which the records of the errors would be destroyed.

In its regular use the physicians' index is a service analysis which shows the results achieved by each service.

Both the staff summary and the service analysis are made in code, each physician being designated by a code number, the key to the code being kept by the medical records librarian.

From the analysis of the work of the individual members of the medical staff recommendations are made for granting privileges and for appointment to the various services and divisions of the medical staff, these being based solely on the appraisal of competence. (Fig. 4.) It is usual to make more recommendations for each appointment than are required to fill the number of vacancies available, thereby allowing consideration of other factors when actually making appointments.

When these recommendations are made the confidential record and its use may be sanctioned as follows:

1. Any physician may have access to his own portion of the index at any time.

2. A committee appointed by the medical staff for the purpose of making recommendations for granting privileges or for appointment to various positions may have access to the index insofar as this is necessary to the performance of the duty for which the committee is appointed.

At the end of the year all columns of the physicians' index are totalled and these totals are carried to a summary sheet showing the work of the medical staff as a whole. (Fig. 3.)

A second summary which is of value is a

FIGURE 3

SUMMARY of an AUDIT of PROFESSIONAL SERVICES

Doctor	Present Service	Cases reviewed				1		2		3		4		5		6		7		8		9		Incomplete record	Results			Conclusions
		Major	Intermediate	Minor	Totals	R	O	R	O	R	D	R	O	R	O	R	O	R	O	R	O	R	O		Favorable	Inevitable	Justifiable	
2	Courtesy	35	10	6	51	47						4												1	50			No conclusions warranted
4	Active Surgery	720	60	23	803	715	3	16	1	5	4	34		7		2	2	7		3		1	3		800		3	Eligible for reappointment
7	Active Urology	80	21	40	141	108	3	11	2	1	4	1		1	2		1			4	1		2	1	138	1	1	Consult in nonurological cases
12	Active Obstetrics	460	5		465	427	1	8	2	10		1	2	1			6	3		1			3		465			Eligible for reappointment
16	Courtesy	40	20	24	84	74	1	1	3	1	1			1				1					1		83		1	Apparently competent
23	Active E.E.N.&T.	2	200		202	193		3	1					5											201		1	Conclusions based on records not warranted in this specialty
44	Associate Gynecology	8	16	4	28	23		1				2						1		1					28			No conclusions warranted
48	Associate Surgery		7	59	63	60		1				1		1											63			Increase responsibility
(Others not shown)																												
Totals		172	630	158	2508	1920	20	116	25	22	35	149	3	28	10	12	40	32	3	46	10	9	28	3	2439	46	19	

FIGURE 4

RECOMMENDATIONS FOR STAFF APPOINTMENT

Active — Surgical Service — 1, 6, 18, 31, 37, 39, 44, 51, 66
Medical Service — 5, 8, 20, 34, 38, 41, 45, 68
(Similar for other services)

Associate — Surgical Service — 4, 9, 12, 19, 24, 29, 33, 46
Medical Service—10, 16, 17, 23, 27, 30, 36, 43
(Similar for other services)

Courtesy Staff — 2, 13, 15, 40, 52, 56, 59, 60, 63, 64, 67
Require that they became members of the staff if they desire continued privileges — 3, 47, 48, 50

name of the physician is substituted for the code number, and in arriving at a decision other factors — such as ability to devote sufficient time to the service, coöperativeness and personality — are given proper consideration.

The results secured from Professional Service Accounting may be summarized as follows:

1. Each member of the medical staff may have a record of his successes and failures.

Continued on page 52

A Study of 100 Gall-Bladder Cases

Leo F. King, M. D., F. A. C. S., Lowell, Massachusetts

It is with considerable satisfaction that these one hundred cases have been analyzed, not only because of the low mortality rate, but rather that we have gained what we hope will be a lesson in our next series of gall-bladders. We study these cases more to recognize our mistakes of commission and omission and to establish a routine to correct our faults.

These cases were all performed during the past few years at St. Joseph's Hospital, Lowell, Massachusetts, a hospital of about 175 beds where the surgeon on service has to do general surgery as well as orthopedic and traumatic surgery. These cases, therefore, are not results gained from a clinic of specialized abdominal surgery but by a general surgeon in ordinary hospital work. These cases were not chosen cases but they represent our last hundred cases as they were referred to the hospital either through the Out-patient department or by other doctors.

It would seem that before presenting the analysis it would be wise to say a word about our preparation of cases, our type of operation preferred, our choice of surgical procedure in acute gall-bladders and our department of anesthesia.

Preparation of Cases:

A thorough study of all cases is made not only clinically but by complete laboratory and X-ray studies. The figures as shown in our analysis of X-ray studies are quite misleading in that 40 cases referred to us had already been X-rayed and we have no X-ray reports in our own records. In a community like ours the doctor referring the case usually calls the man on service and gives him the history and also whether or not X-rays were negative or pathological. It is most interesting to note that of the sixty cases X-rayed, twelve were reported negative and yet at operation definite pathology of the biliary tract was found.

Complete blood analysis is done routinely on all patients as well as urine analysis and blood chemistry. The indicated therapeutic agents, be they transfusions, infusions or medications are given. Cardio-graphic studies are frequent and also basal metabolism tests. Vitamin K is given routinely before operation to all our operative cases.

Once the patient is considered prepared, the department of anesthesia is called in to determine the type to be used. Here let me give credit to this department which has helped me to such a degree that we have had no mortality from anesthesia in this series. Two cases were done under regional 1% novocaine infiltration. These two cases were very sick individuals with empyema of gall-bladder who were sent to us in extremely bad condition. One died the same day and the other died on the 16th day due to metastactic liver abscess. Five cases were done under special novocaine anesthesia. We do not particularly care for spinal anesthesia in gall-bladder work. Sixty cases were performed under cyclopropane anesthesia which we enjoy very much in all our abdominal surgery. The relaxation is excellent, the recovery from anesthesia is more rapid and with much less nausea and vomiting and we believe the effect on our blood chemistry has been very negligible.

Three cases were performed with avertin. These patients were very apprehensive and demanded that they be put to sleep before going to the Operating Room. One had to be supplemented with Gas-oxygen but the other two were completely performed without any additional agent. Avertin has a very limited use in our experience. Small doses are probably good as a basal anesthesia but we do not recommend its use too freely.

Gas-oxygen and ether were used in the remaining thirty cases and it is pretty hard to deny that this combination is probably the most reliable and the anesthesia of choice in the majority of cases.

CASE NO.	AGE	SEX	PRE-OPERATIVE DIAGNOSIS	POST-OPERATIVE DIAGNOSIS	TYPE OF OPERATION	TYPE OF ANESTHESIA	COMPLICATIONS	INFECTION	X-RAY	END RESULT	DAYS IN HOSP.
1298-33	46	F	Empyema of Gall Bladder	Same and Hepatitis	Drainage of Gall Bladder	Novacaine 1%—local	Metastasis of Liver	None	Pathological	Died	16
712-33	70	F	Empyema of Gall Bladder	Cholelithiasis-Hepatitis	Cholecystotomy	Novacaine 1%—local	None	None	Negative	Died	1
300-33	46	F	Cholecystitis	Same	Cholecystectomy	Avertin N20	None	None	None	Improved	22
161-33	46	M	Cholelithiasis with stones	Same	Cholecystectomy	Spinal	None	None	None	Improved	20
293-34	54	F	Cholelithiasis	Same	Cholecystectomy	Ether	None	None	No stones	Improved	20
302-34	49	M	Acute Cholecystitis	Same	Cholecystectomy	Ether	None	None	Pathological	Improved	26
601-34	39	F	Cholelithiasis and Rt. Ing. Hern.	Same	Cholecystectomy Herniorraphy	Spinal 150 mgms.	None	None	Pathological with stone	Improved	23
153-35	44	F	Acute Cholecystitis	Same	Cholecystectomy	Ether	None	None	None	Recovered	21
376-35	52	F	Cholecystitis-Cholelithiasis	Sub-acute Cholecystitis-Cholelithiasis	Cholecystectomy	Ether	None	None	None	Improved	20
502-35	40	M	Chronic Cholecystitis	Same and Cholelithiasis	Cholecystectomy	Ether	None	None	Pathological	Improved	21
1101-35	37	M	Chronic Cholecystitis	Same	Cholecystectomy Removal of Cysts	Gas and Ether	None	None	None	Improved	16
760-36	35	F	Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Ether	None	None	None	Improved	21
1199-36	25	F	Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Gas and Ether	None	None	None	Improved	14
2246-36											
515-36	57	M	Cholelithiasis	Chronic Cholecystitis with multiple adhesions	Cholecystectomy	Gas, Oxygen and Ether	None	None	Negative	Cured	20
367-37	56	M	Chronic Cholecystitis with Cholelithiasis	Same	Cholecystectomy	Avertin and Ether	Uremia	None	No stones	Died	12
380-37	67	F	Chronic Cholecystitis with Cholelithiasis	Same	Cholecystectomy	Cyclopropane	None	None	None	Improved	17
400-37	62	F	Acute Cholecystitis and Cholelithiasis	Same	Cholecystectomy	Cyclopropane	None	None	Pathological	Improved	32
1377-37	28	F	Cholelithiasis	Same	Cholecystectomy	Ether	None	None	None	Improved	16
1859-37	62	F	Chronic Cholecystitis with Cholelithiasis	Same	Cholecystectomy	Avertin	None	None	Pathological	Improved	22
2789-37	41	M	Cholecystitis	Same	Cholecystectomy	Cyclopropane Oxygen-Ether	None	None	None	Improved	16
72-38	25	F	Cholelithiasis	Same	Cholecystectomy Appendectomy	Ether	None	None	Pathological	Improved	17
204-38	24	F	Chronic Cholecystitis	Same with Cholelithiasis	Cholecystectomy	Ether	None	None	Pathological	Improved	22
232-38	35	F	Cholecystitis-Cholelithiasis	Same	Cholecystotomy	Cyclopropane and Oxygen	None	None	Pathological	Improved	18
536-38	28	F	Chronic Cholecystitis	Same	Cholecystectomy	Nitrous Oxide and Ether	None	None	None	Improved	21
1131-38	34	F	Non-functional atrophic Gall Bladder	Same	Cholecystectomy	Cyclopropane E & O	Hepatitis	None	None	Improved	14
1192-38											
1247-38	58	F	Chronic Cholelithiasis with C. A.	Same	Cholecystectomy	Cyclopropane E & O	Glomerular Nephritis (Uremia)	None	Pathological	Died	16
2185-38	45	F	Chronic Cholecystitis	Same	Cholecystectomy	Cyclopropane Ether	None	None	None	Improved	14
3070-39	24	F	Chronic Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Cyclopropane O & E	None	None	None	Improved	14
510-39	61	F	Chronic Cholecystitis with adhesions at base	Same	Cholecystectomy	Cyclo-Nitrous	None	None	None	Improved	15
927-39	41	F	Cholecystitis	Same	Cholecystectomy	Cyclo-O & E	None	None	None	Cured	13
953-39	58	F	Chronic Cholecystitis and Cholelithiasis	Same	Cholecystectomy	Cyclo-Oxygen	None	None	None	Improved	13
536-40	46	F	Chronic Cholecystitis	Same	Cholecystectomy	G. O. E.	None	None	None	Improved	14
634-40	47	F	Acute Cholecystitis with Cholelithiasis	Same	Cholecystectomy	G. O. E.	None	None	None	Improved	14
657-40	45	F	Sub-acute Cholecystitis and Cholelithiasis	Same	Cholecystotomy	G. O. E.	None	None	Pathological	Improved	29
725-40	21	F	Chronic Cholecystitis with Cholelithiasis	Same	Cholecystectomy	G. O. E.	None	None	Pathological	Improved	17
875-40	47	F	Stone in Cystic Duct	Cholelithiasis	Cholecystotomy	Cyclo-O	None	None	None	Improved	13
1174-40	21	F	Chronic Cholecystitis	Same	Cholecystectomy	Cyclo-O-E	None	None	Pathological	Improved	16
1423-40	38	F	Chronic Cholecystitis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Recovered	14
116-40	41	F	Chronic Cholecystitis	Same	Cholecystectomy	Cyclo-O	None	None	None	Improved	13
3197-40	44	F	Chronic Cholecystitis	Same	Cholecystectomy	Cyclo-O-E	None	None	Pathological	Improved	21
2681-41	62	F	Cholecystitis and Cholelithiasis	Same	Cholecystotomy	Avertin G.O.E.	None	None	Normal	Improved	21
189-41	49	F	Chronic Cholecystitis and Cholelithiasis	Same	Cholecystectomy	G. O. E.	Pneumonia	None	None	Cured	32

593-41	21	F	Chronic Cholecystitis and Cholelithiasis	Same	Cholecystectomy	G. O. E.	None	None	None	
809-41	49	M	Cholecystitis and Cholelithiasis	Same	Cholecystotomy	Cyclo-O-E	None	None	Pathological	Improved	16
647-41	42	F	Chronic Cholecystitis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Cured	18
890-41	48	F	Cholecystitis-Cholelithiasis	Same	Cholelithotomy	Cyclo-O-E	None	None	Stones	Improved	20
1163-41	57	F	Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	14
1808-41		F	Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	12
1816-41	66	F	Cholecystitis-Cholelithiasis	Same	Cholecysteetomy	Cyclo-O-E	None	None	Pathological	Improved	17
3234-41	39	F	Cholecystitis-Cholelithiasis	Same	Cholelithotomy	Cyclo-O-E	None	None	Pathological	Improved	16
2357-41	55	F	Acute Cholecystitis	Same	Cholecystectomy	Cyclo-O-E	None	None	Normal	Cured	15
2719-41	41	F	Cholecystitis	Same	Cholecystectomy	Avertin Cyclo-O-E	None	None	Pathological	Improved	12
2757-41	59	F	Cholecystitis and Cholelithiasis	Same	Cholecystectomy	G. O. E.	None	None	Pathological	Cured	25
2952-41	46	M	Cholecystitis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	13
3102-41	42	M	Cholecystitis-Cholelithiasis	Same	Cholecystotomy wtih drainage	Cyclo-O-E	None	None	None	Improved	14
3140-41	48	F	Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	14
				Same	Cholecystectomy Rep. of Rectocele	Cyclo-O-E	None	None	Pathological	Improved	23
3187-41	44	F	Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Cyclo-O-E	None	None	Pathological	Improved	23
2233-41	57	M	Chronic Cholecystitis	Ruptured Gall-Bladder and Peritonitis	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	15
1-42	49	F	Cholecystitis-Cholelithiasis	Same	Cholecystotomy with drainage	Cyclo-O-E	Peritonitis	None	None	Improved	54
94-42	57	M	Intestinal Obstruction								
185-42	58	F	Cholecystitis-Cholelithiasis	Same	Cholecysteetomy	Cyclo-O-E	Pulmonary Embolism	None	None	Died	14
259-42	24	F	Cholecystitis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	12
2929-42	55	F	Cholecystitis-Cholelithiasis	Same	Cholecystotomy	Cyclo-O-E	None	None	Pathological	Improved	34
3337-42	60	F	Cholecystitis-Cholelithiasis	Same	Cholelithotomy	G. O. E.	None	None	Pathological	Improved	21
613-42	52	F	Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	15
639-42	34	F	Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	17
631-42	47	F	Cholecystitis-Cholelithiasis	Same	Cholecystotomy	G. O. E.	None	None	Pathological	Improved	18
778-42	38	F	Chronic Cholecystitis	Same with Cholelithiasis	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	11
890-42	45	F	Chronic Cholecystitis	Same with Cholelithiasis	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	14
1595-42	25	F	Acute Cholecystitis	Same	Cholecystectomy	Cyclo-O-E	None	None	Pathological	Cured	14
1603-42	36	F	Chronic Cholecystitis	Same	Cholecysteetomy	Gas-Ether	None	None	None	Cured	16
1672-42	27	F	Chronic Cholecystitis and Cholelithiasis	Same	Cholecystectomy	G. O. E.	None	None	Pathological	Cured	13
1699-42	42	F	Chronic Cholecystitis with Cholelithiasis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Cured	14
2536-42	40	F	Chronic Cholecystitis	Same	Cholecystectomy	G. O. E.-Cyclo	None	None	Pathological	Cured	14
3012-42	35	F	Cholecystitis with Cholelithiasis	Same	Cholecystectomy	Cyclo-O-E	None	None	Pathological	Improved	21
3015-42	47	F	Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Cyclo-O-E	None	None	Pathological	Improved	21
3045-42	59	F	Cholecystitis-Cholelithiasis	Cholelithiasis	Cholecystectomy	G. O. E.	None	None	Pathological	Cured	15
3121-42	47	F	Cholecystitis-Cholelithiasis	Same	Cholecysteetomy	Cyclo-O-E	None	None	Pathological	Improved	21
3446-42	59	F	Cholecystitis-Cholelithiasis	Same	Cholecystectomy	Cyclo-O-E	None	None	None	Improved	21
3799-42	64	F	Chronic Cholecystitis	Same	Cholecystectomy	G. O. E.	None	None	Pathological	Improved	25
3821-42	56	F	Cholecystitis	Chronic Cholecystitis	Cholecystectomy	Cyclo-O-E	None	None	None	Cured	17
119-43	53	M	Cholecystitis-Cholelithiasis	Same (Chronic)	Cholecysteetomy	Cyclo-O-E	None	None	Normal	Improved	17
133-43	32	F	Cholecystitis-Cholelithiasis	Same	Cholelithotomy	Cyclo-O-E	None	None	Pathological	Improved	18
191-43	34	F	Cholecystitis	Chronic Cholecystitis	Cholecystectomy	Cyclo-O-E	None	None	Pathological	Cured	13
367-43	52	F	Cholecystitis-Cholelithiasis	Chronic Cholecystitis	Cholecystectomy	Avertin-Cyclo-O-E	None	None	Pathological	Cured	14
550-43	54	F	Cholecystitis-Cholelithiasis	Chronic Cholecystitis	Cholecystectomy	Cyclo-O-E	None	None	Pathological	Cured	26
561-43	54	F	Acute Cholecystitis	Same with Cholelithiasis	Laparotomy and Cholelithotomy	Cyclo-O-E	None	None	Negative	Improved	20
578-43	52	F	Cholecystitis-Cholelithiasis	Same (Chronic)	Cholecystectomy	G. O. E.	None	None	Pathological	Improved	19
635-43	68	F	Cholecystitis	Ruptured Gall Bladder	Cholelithotomy	Avertin	None	None	Pathological	Improved	30
819-43	54	F	Cholecystitis-Cholelithiasis	Same	Cholelithotomy	Cyclo-O-E	None	None	Pathological	Improved	24
968-43	45	F	Cholecystectomy-Appendectomy (Cholecystitis)	Same	Cholecystectomy and Appendectomy	Cyclo-O-E	None	None	Pathological	Improved	17
1033-43	34	M	Cholecystitis	Same with Chronic Appendicitis	Cholecystectomy and Appendectomy	Cyclo-O-E	None	None	Pathological	Improved	16
1308-43	47	F	Cholecystitis-Cholelithiasis	Chronic Cholecystitis	Cholecystectomy	Cyclo-O-E	None	None	Pathological	Cured	13
1314-43	54	M	Adhesions, Cholecystitis	Hyperplasia of Lymph Gland	Cholecysteetomy	Spinal (Nov.)	Lobar Pneumonia	None	Pathological	Improved	21
1414-43	43	M	Post-Operative Adhesions	Same with Chronic Cholecystitis	Cholecystectomy Lyses of Adhesions	Spinal (Cont.)	None	None	Pathological	Improved	18
1430-43	62	M	Cholecystitis-Cholelithiasis	Same	Cholelithotomy	Cyclo-O-E	None	None	None	Improved	17
1449-43	32	F	Cholecystitis	Same	Cholecystectomy	Spinal (Nov.)	None	None	Pathological	Cured	13
1545-43	34	F	Acute Cholecystitis	Same with Acute Diffuse Appendicitis—Chronic Cholecystitis	Cholecystectomy Appendectomy	Cyclo-O-E	None	None	None	Improved	14
1561-43	31	F	Cholecystitis-Cholelithiasis Incidental Appendix	Chronic Cholecystitis Chronic Appendicitis	Cholecystectomy Appendectomy	Cyclo-O-E	None	None	Pathological	Improved	14

Type of Operation:

We have standardized our type of operation to a great extent unless some anatomical surprise makes us adjust our mechanics. We have done it for two reasons: first, because we like to think we are teaching our internes the ideal and routine type of operation; secondly, because we claim our method is the easiest and most likely successful type of operation. Our incision is a right rectus incision from the lower costal margin down to level of umbilicus. This longitudinal incision should end about 5 c.m. parallel to umbilicus. The abdominal cavity is first thoroughly inspected. We feel that if more time were spent to inspect all organs that many more early cases of malignancy could be saved. Following inspection and palpation, the gall-bladder is inspected and the intestines and stomach are displaced with careful placing of salt-packs. No surgery is allowed to begin until the Foramen of Winslow is located and a sponge placed behind the common duct and artery. The reason for this is that any unfortunate injury to cystic or hepatic artery can be controlled very readily without fatal hemorrhage. The gall-bladder now being exposed, is dissected from above downwards. You will note that there are no so-called liver deaths in our series and we believe that such cases were caused by injury to the circulation of the liver. No injuries to the hepatic artery or common duct are very apt to occur if the gall-bladder is removed in this fashion. The gall-bladder once freed from its liver bed is easily removed with complete exposure of its pedicle and any anomaly that may exist is readily seen. Two-stay sutures are placed in the pedicle, one is called the "sleeping suture." The gall-bladder is then cut off, its stump cauterized with merthiolate. A penrose drain is then placed against stump and one of the pedicle ligations lightly tied around drain to prevent displacement of drain. The abdomen is then closed in three layers, the drain is left at its upper position but always a suture is placed in peritoneum and fascia respectively above the drain. This, we believe, is an additional reason why we have not had persistent sinuses or wound sepsis.

Choice of Treatment in Acute Gall-Bladders:

Much has been written about this subject and no doubt we will have a great deal of criticism on our choice of treatment but we believe our end results speak for themselves. No greater problem presents itself in surgery than the question of when to operate in acute gall-bladders. Our method is rather simple: Once a good differential diagnosis has been made; that is, the question of acute pancreatitis, ruptured ulcer of stomach, hernia of diaphragm, or ruptured appendicitis has been eliminated, we place an ice-bag to upper right quadrant and give plenty of fluid and morphia. Next a period of watchful waiting consisting of white-blood count every 12 hours, 4° temperature chart and physical examination every twelve hours. The white count is of very little help except when it suddenly jumps from 12,000 or 15,000 to 25,000 or 30,000, then we feel that surgical intervention is necessary. The temperature is a much safer guide; if there is a sudden rise, then again we do not hesitate to explore. Physical examination is still probably the best guide; if the spasm and rigidity increases noticeably, or if vomiting occurs or the pain increases appreciably during the period of observation, then we operate.

We never remove an acutely inflamed gall-bladder, especially if there is any evidence of hepatitis. Here we will be severely criticised because many believe it should be removed just as an acute gangrenous appendix should be. Our experience convinces us that conservative treatment gives low mortality rate. In cases of acute inflammation or even to the point of gangrene in the gall-bladder, the fundus is opened, the contents are gently curetted out, a catheter placed in gall-bladder and the fundus and catheter are sewn to the peritoneum. Once the acute process has subsided, the patient is discharged and is not re-operated until a period of sixty and preferably ninety days has elapsed. The only two cases that we lost from acute gall-bladder in our series was one that was admitted practically moribund and the other had a metastatic liver abscess. We still think that conservative gall-bladder surgery pays dividends.

Type of Pathology Found:

In 67 cases stones were found in the gall-bladder and of these, 4 had stones in the common duct. The remaining 33 cases were chronically inflamed gall-bladders which did

not empty and were markedly distended. In all these 33 cases, the laboratory findings confirmed our clinical diagnosis of pathological gall-bladders.

Four cases of common duct stones out of 100 cases is not a true picture. If we were to rely only on our hospital records we would assume this to be true, but at least ten of our cases were seen subsequent to discharge with typical gall-bladder attacks. All but one subsided with no further attacks and that one had to be re-operated and a stone removed from the common duct. We now believe that palpation is not sufficient in deciding whether or not to explore common ducts. If stones are found in gall-bladder, all ducts should be explored. This can be done much easier now than to have to re-open an abdomen full of adhesions where there are no land-marks by which to find the common duct. An argument has been used that probing all common ducts induces strictures by trauma, contamination, prolonged shock to patient. That is not true if one has experience to do this procedure gently and with extreme precaution. Therefore, we have learned from this series that more ducts should be explored.

Analysis of the Five Deaths in This Series:

The first case was that of a 70-year-old woman who had been treated for several weeks on the outside and was sent in very toxic and with evidence of peritoneal irritation. Our choice of drainage under 1% novocaine field block we thought, was her only chance in that we suspected a ruptured gall-bladder, otherwise we would have temporized and tried to get our patient in better condition.

Case number two was also an empyema of a gall-bladder with a large stone in a woman of 46. Under 1% novocaine field block the gall-bladder was opened, the contents suctioned out, the stone removed. Extensive hepatitis was evident. She did well for a few days and then gradually showed evidence of infection and gradually died a toxic death on the 16th day. Autopsy revealed a large abscess in the liver itself extending inwards from the base of gall-bladder.

The next two cases were ordinary removals of gall-bladder with stones and although no evidence of urinary tract disease was found preoperatively, they died on the 12th and 16th days, respectively, from acute suppression of urine in spite of all efforts to combat the kidney condition. One of these patients was a male of 56, the other a female of 58. The latter case also had shown at operation extensive carcinoma of head of pancreas which was believed inoperable.

The 5th case was one of those most sudden deaths. A woman, 58 years of age, who had successfuly recovered from Cholecystectomy and was about to go home on her 16th day when she suddenly collapsed and expired. Autopsy revealed a pulmonary embolism.

In our treatment of these five cases we would, therefore, make very little change if we were to be confronted with the same problems. The first case perhaps would have been better off if we had not operated and yet we were not uncertain that she did not have a ruptured gall-bladder. The cases of uremia are always a danger in spite of careful preparation of patients for any type of surgery and finally emboli are still the stumbling block to any surgeon.

Besides these fatal cases we had a few other complications. There were two cases of upper respiratory infection. One was an inhalation pneumonia which followed gas-oxygen-ether anesthesia. At that time we were not equipped for aspiration and we feel now that we can practically eliminate this complication. This patient recovered and went home after 32 days' hospitalization.

The second upper respiratory case was a lobar-pneumonia which occurred during the convalescence period but recovered very rapidly with the aid of sulphonamides.

We had but one case of infection and that was a case of ruptured gall-bladder. This was drained and the peritonitis soon subsided and the patient made a complete recovery without any secondary infections subsequent to operation.

Other Statistics Derived from Our Series:

The average age of our patients was 45.1 years old. There were 17 males and 83 females and 67% of our cases had some type of stones either in the bladder or duct while in 33 there were none.

Continued on page 52

Editorials

Sulfadiazine for Carriers of Cerebrospinal Meningitis

Carriers of Neisseria intracellularis, the bacteria which causes epidemic cerebrospinal meningitis and which also is known as meningococcus, given a single dose of 2 Gm. of sulfadiazine rapidly became free of these organisms in cultures taken from the nose and throat, the time varying from twelve to twenty-four hours. Major Isadore Pilot, Medical Corps, Army of the United States, reports in *The Journal of the American Medical Association* for February 10. He warns, however, that the number of men in the series of studies was too small to determine completely the efficacy of the treatment, inasmuch as the carrier state returned in some cases.

"Further studies," Major Pilot says, "are necessary to determine the causes of the return of the carrier state. Inadequate dosage may be the most frequent factor when the single dose of 2 Gm. is given without regard to body weight. Under crowded conditions reinfection may reestablish quickly the carrier state by introducing other strains of Neisseria. However, local factors such as infections of the nose and accessory sinuses should be investigated in instances in which the same type or another type of Neisseria intracellularis persists or recurs repeatedly."

He explains that the percentage of carriers depends on the number and frequency of cultures made of the nose and throat of individuals and that the carrier rate is quite variable in the various reports that have appeared in the medical literature. In his study, a single culture of the nose and throat was made on a group of soldiers and on a group of civilians who were being inducted into the Army. This study was made in the spring of 1944 of 28 soldiers. Six (21.4 per cent) had positive cultures and out of 25 inductees from whom a single culture was taken immediately on arrival from the train, there were 5 positives (20 per cent). Major Pilot says that apparently the civilian carrier rate is approximately the same as that of Army personnel. For the purpose of determining the effect of sulfadiazine, 4 carriers among laboratory personnel were studied at frequent intervals to note the results from the administration by mouth of a single dose of 2 Gm. of sulfadiazine. In two hours no changes were observed, in six hours the number of colonies of Neisseria intracellularis dropped considerably, in twelve hours the colonies were few, and in twenty-four hours and subsequently they were absent.

Major Pilot says that the effect of sulfadiazine on the various organisms found in the nose and throat was noteworthy. After six to twelve hours the decrease in the number of colonies varied from 25 to 50 and remained depressed for twenty-five hours more. In three to five days the flora gradually returned to previous numbers except for Neisseria intracellularis.

No untoward effect or reactions were observed in the carriers as the result of the administration of sulfadiazine.

Two additional soldiers, carriers of type I of Neisseria intracellularis, were subsequently treated by the 2 Gm. dose of sulfadiazine. One remained negative for a week, left the post, and returned in thirty days when his cultures were again positive, but on typing the strain at this time, belonged to type II. The other carrier was a heavy soldier, weighing 220 pounds. His blood level of sulfadiazine did not go as high as in the other soldier. However, cultures of his nose and throat remained negative for eleven days after the treatment and then became positive for type I. A larger single dose of sulfadiazine (4 Gm.) was given. This time his blood level of the drug was much higher and Neisseria intracellularis again rapidly disappeared from his nose and throat.

New Method Measures Concentration of Penicillin in Body Fluids

The results of observations made on penicillin levels in the blood and other body fluids by the use of a relatively simple method which has yielded apparently consistent results and some useful information, are reported by Jean V. Cooke, M. D., and David Goldring, M. D., St. Louis, in *The Journal of the American Medical Association* for January 13.

The absorption and distribution of penicillin in the various body fluids after parenteral injection (beneath the skin or into a vein) and the duration of its survival in body fluids or cavities under normal or disease conditions are questions of considerable interest in penicillin treatment, the two authors point out. Although some studies have been made in certain cases, there has apparently been no method for such measurements that was easily applicable to routine observations in patients.

The method they describe consists in determining the smallest amount of the fluid from a patient which will produce complete inhibition of a standard strain of Staphylococcus aureus.

The results the two physicians report were obtained from patients who for the most part were infants and children in St. Louis Children's Hospital, who were receiving penicillin treatment and in addition a few adults in the Barnes Hospital.

They found that after injections into a muscle the concentration of penicillin in the blood reached its highest level within thirty minutes, was still moderately high at one hour and fell rapidly during the second hour but often persisted at lower levels for three to four hours. Blood levels after injection beneath the skin were quite similar to those after injection into a muscle.

Complications of Pneumonia

With the advent of penicillin and other powerful antibacterial drugs and specific agents for the treatment of pneumonia, supportive treatment may be as important as the antibacterial, four Boston physicians point out in *The Journal of the American Medical Association* for February 10.

S. Howard Armstrong, Jr., M. D., Albert C. England, Jr., M. D., Cutting B. Favour, M. D., and I. Herbert Scheinberg, M. D., report 2 cases of severe and progressive anemia and hypoproteinemia (a deficiency of proteins in the blood) which developed in patients with extensive and protracted bacterial pneumonia being treated with penicillin.

They say that although these complications hitherto have been rarely seen in pneumonia, they "may occur with increasing frequency as specific agents permit prolonged survival in the face of infections otherwise rapidly fatal."

In one of the cases, they explain, the anemia and hypoproteinemia of nutritional origin probably antedated the pneumonia because the patient, a man aged 85, had been on a deficient diet for several years. In the other case the anemia and hypoproteinemia developed after the onset of pneumonia.

"In these patients," the four physicians say, "enormous amounts of whole blood and plasma were required to counteract the progression of the anemia and hypoproteinemia. The fact that this therapy [treatment], together with nearly all known measures for maintenance of optimum . . . [availability and utilization of oxygen] in remaining functional lung tissue, appeared necessary to maintain life for some time after apparent bacteriologic arrest of the infection [pneumonia] suggests that, in pneumonia of this severity, development of anemia and hypoproteinemia should be anticipated by early use of whole blood and plasma together with adequate protein dietary intake."

Treat Vincent's Angina by Dissolving Sulfathiazole Tablet on the Tongue

By treating Vincent's angina (an infectious, mildly contagious disease affecting the membranes of the mouth) with a sulfathiazole tablet dissolved on the tongue every two hours during the day and two such tablets dissolved in such manner every four hours at night, the treatment time on the average case has been cut from ten days to seventy-two hours, Lieutenant Commander William W. Manson (MC), U. S. N. R., and Lieutenant Commander Irwin T. Craig (MC), U. S. N. R., declare in *The Journal of the American Medical Association* for February 3 in reporting on the results they obtained in 48 cases of this disease. In all of the cases reported by them, the infection was confined to the tonsils.

That Vincent's organisms are frequently found in smears taken from a normal mouth is now common knowledge, the two Naval officers explain. These organisms have been found in about 75 per cent of adult mouths examined, in spite of the absence of symptoms of the disease. At one time it was thought that the arsenicals used in the treatment of syphilis were effective for Vincent's angina, but subsequent investigations have indicated that neither arsenic nor bismuth is effective.

Describing the results obtained from their treatment, the two doctors say that "The temperature usually returned to normal in twenty-four hours and the symptoms had almost completely disappeared by that time. In spite of the clinical improvement, the treatment was continued for a total of seventy-two hours, except in very mild cases, when it was terminated at the end of forty-eight hours. . . .Lesions were invariably cleared up in ninety-six hours after beginning treatment . . . .

"This series comprises 36 cases treated by the method described. No case was treated with sulfathiazole for over seventy-two hours, the total dosage in these cases being 18 Gm. The milder cases received forty-eight hours of treatment for a total of 12 Gm. of sulfathiazole. Results were uniformly good in the two groups. Average sick days were 3.75 for this group, which is much shorter than that obtained with the older methods [of treatment] employed at this activity [Naval Station]. These older methods included the use of neoarsphenamine locally as well as intravenously [injection into a vein]. . . .

"The results have been so satisfactory in these cases that we have adopted this method as the routine treatment of all cases which demonstrated clinical Vincent's angina. . . ."

The authors explain in a footnote that since the 36 cases were reported, 12 additional ones have been treated by the same method without recurrences.

---

70 Physicians Killed in Action Were Listed in The Journal of the American Medical Association in 1944

During 1944 the obituaries of 70 physicians who were killed in action during World War II and those of 113 who died while in military service were published in *The Journal of the American Medical Association,* it is reported in the January 13 issue.

Since the outbreak of World War II, *The*

Continued on page 51

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Albert W. Moulton, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

100% Paid Membership for 1945
Piscataquis County Medical Society
Franklin County Medical Society

Cumberland

A meeting of the Cumberland County Medical Society was held Friday, February 16th, at the Maine General Hospital, Portland, Maine. The activities began with a surgical clinic at 5.00 P. M., at which time several interesting surgical problems were presented to a relatively large group of members from Cumberland County, and to members of the armed forces who were in attendance. Following the clinic, dinner was served in the main dining room at 7.00 o'clock and the meeting called to order in the assembly room of the hospital at 8.00 o'clock by the President, Doctor Albert W. Moulton. There was a minimal amount of business to be attended to at this meeting. A nominating committee was appointed by the president, consisting of the following members: Drs. C. L. Richardson, Roderick L. Huntress, H. Eugene Macdonald, Isaac M. Webber, and Harry L. Curtis.

Doctor Robert Linton, of Boston, gave a most interesting and instructive paper on *Surgery of the Major Arteries and Veins.* The paper was divided into subdivisions, namely: the treatment of popliteal aneurysms and the diagnosis and treatment of thromboembolic disease. Doctor Linton has had a wide experience in the treatment of both of these conditions, and during the past five years has had the opportunity of seeing a large number of both arterial and venous conditions requiring surgical therapy, at the Massachusetts General Hospital. The technique of removal of popliteal aneurysms and the ligation of femoral veins were well illustrated by excellent colored moving pictures. He gave numerous useful and valuable hints as to both pre-operative and post-operative care of patients with these conditions, and emphasized particularly the importance of early diagnosis of thromboembolic disease, because by its early recognition and prompt surgical treatment we are able to reduce the incidence of fatal pulmonary emboli. Bilateral ligation of the femoral vein in patients who have thromboembolic disease will also reduce their hospitalization from three to four weeks to an average of eight to nine days.

The meeting was well attended, and the discussion was entered into by many of those present.

Joseph E. Porter, M. D.,
Secretary.

Pay Your 1945 State and County Dues to Your County Secretary

Franklin

The Franklin County Medical Society held its annual meeting Monday, January 8th, at Farmington, Maine. Only routine business was brought up.

The following officers were elected for 1945:

President, Albion E. Floyd, M. D., New Sharon.

Vice President, Cecil F. Thompson, M. D., Phillips.

Secretary-Treasurer, George L. Pratt, M. D., Farmington.

Delegate to the 1945 annual session of the Maine Medical Association, Dr. Pratt.

Alternate, Dr. Thompson.

Board of Censors: Currier C. Weymouth, M. D., Dr. Floyd, and Dr. Thompson.

George L. Pratt, M. D.,
Secretary.

Hancock

A meeting of the Hancock County Medical Association was held at the Hancock House, Ellsworth, Maine, Wednesday, February 14th, at 6.30 P. M.

The meeting was called to order by the President, Philip L. Gray, M. D.

J. W. Crowe, M. D., reported on the different phases of treatment for poliomyelitis as carried out at the Warm Springs Foundation, Warm Springs, Georgia.

Movies of pattern plaster cast technics, obtained from E. O. Geckeler, M. D., of Hahneman Medical School, were shown and were very interesting and instructive.

J. H. Crowe, M. D.,
Secretary.

Penobscot

The regular monthly meeting of the Penobscot County Medical Association was held Tuesday, February 20, 1945, at the Bangor House, Bangor, Maine.

Following dinner at 6.30 P. M. the scientific session was held.

General subject for discussion was *Joint Injuries.* The speakers were: G. E. Haggart, M. D., Chief of the Bone and Joint Service at the Lahey Clinic, Boston; and Hugh F. Hare, M. D., Chief of the X-ray Department.

The meeting was held with the Medical Group of the Armed Forces at the local Station Hospital as part of the Wartime Graduate Medical Service.

There were forty members and guests present.

Forrest B. Ames, M. D.,
Secretary.

Necrology

Edwin Francis Pierce, M. D., 1872-1945

Edwin Francis Pierce, M. D., passed away at the Central Maine General Hospital, Lewiston, Maine, on February 2, 1945, after suffering a post-operative heart attack.

Doctor Pierce was born in Lewiston, April 13, 1872, the son of Sylvester G. and Jennie E. Barker Pierce. He was graduated from Bates College in 1894 and received his degree in medicine from Columbia University in 1901. He was married to Ethel I. Cummings, a classmate at Bates, on October 5, 1906. Surviving are his widow and a son, Lieut. Eugene Frederick Pierce, USNR, a liaison officer stationed at Orlando, Florida.

Doctor Pierce was a member of the American Medical Association, the local, county, and State medical societies, and of Phi Beta Kappa.

He was a member of the staff at the Central Maine General Hospital throughout most of its growth and devoted much time and effort in its behalf. He served a short time on the medical staff then the remaining years of his life on the surgical staff, and on reaching the retirement age was made a surgical consultant. Doctor Pierce was a keen student of medicine, both the science and art thereof. Among his associates in the medical profession he was highly regarded for his skill, good judgement and loyalty. The medical profession has lost a valued member who was respected by all.

Continued from page 48

Journal says, it has recorded the deaths of 101 physicians who died in action and of 255 who died while in service. *"The Journal,"* it says, "again affirms its opinion that the group of published military deaths does not reflect a true picture of the situation as a whole. The notices received probably represent only a certain proportion of the deaths recorded in Washington and not yet released for publication."

In addition to the obituaries of those killed in action and of those who died while in military service, *The Journal* also published one of a United States Public Health Service officer, aged 31, who died of tsutsugamushi fever while engaged in special war research.

Theaters of operation designated in official reports as those where injuries resulting in death occurred were the Pacific area, 17; European area, 10; France, 12; Italy, 5; North Africa, 6; Atlantic area, 3; Anzio beach head, 3; Normandy, 2; Bougainville, Marshall Islands, Isle of Capri, Guam, Tarawa, Coral Sea, Savo Island and Sicily, each 1; and 1 died enroute from Tunisia to Sicily. Location was not mentioned in 3 obituaries. Of the physicians who were killed in action, 26 died in the age group, 25 and 29; 33 between 30 and 34; 8 between 35 and 39; 2 between 40 and 44; and 1 between 45 and 49.

Of those who died while in military service, 20 were between the ages of 25 and 29; 33, between 30 and 34; 27, between 35 and 39; 15 between 40 and 44; 8, between 45 and 49; 5, between 50 and 54; and 5, between 55 and 59.

During 1944 a total of 3,172 obituaries of physicians were published in *The Journal*. The American Medical Directory Report Service recorded 3,415 deaths of physicans in the United States and possessions, or 243 more deaths than obituaries published in *The Journal*.

From where I sit *by* Joe Marsh

Definition of a Great Man

At Bill Webster's the other evening, we were kidding Bill about his children always saying that their pop's "a great man." Dr. Walters came to Bill's rescue.

"The kids are right," chuckles the doctor. "Everybody in America's a great man. You just can't be part of greatness and not share in it."

In America (he argues) things that used to belong only to the great are common property; a share in government through the right to vote; individual liberties guaranteed by constitution; freedom to speak one's mind; to work at what one pleases; to choose what one likes to eat or drink . . . whether beer or buttermilk.

But from where I sit, there's one important point to add . . . to make the doctor's definition ring true. We must be worthy of this greatness. We must have the humility to appreciate these blessings . . . never abuse them with intolerance, intemperance, or indifference.

Joe Marsh

Professional Service Accounting
Continued from page 40

2. Privileges to be granted are determined by an appraisal of the competence of each physician, this appraisal being based on a careful consideration of recorded data.

3. Service appointments and promotions are based on the same evidence of competence, but other factors may be considered also.

4. Deficiencies in equipment or errors in general procedure will be discovered and means may be taken for correction.

The following are considered as essential to the success of a system of Professional Service Accounting:

1. Accurate and complete case studies.

2. Constructive criticism with no spirit of fault finding.

3. Honesty and fearlessness in dealing with errors.

4. Observance of the confidential nature of all records kept under the system.

A Study of 100 Gall-Bladder Cases
Continued from page 45

The average hospital stay for these cases was 20.1 days. This does not mean after operation but the entire stay. Some of these patients were in several days before a proper diagnosis or proper preparation was made. It also includes all the days due to any complications. Our ordinary length in bed following operation was 10 days; now, however, with the shortage of beds it is our tendency to shorten this period to 8 or 9 days in normal convalescence.

Summary and Conclusions:

1. Average age of patient—45.1.

2. 83% females and 17% males in our series.

3. Average hospital stay, 20.1 days.

4. 67% of our cases had stones either in duct or bladder.

5. We believe that conservative surgery in acute gall-bladders, especially with the presence of hepatitis, is the proper procedure.

6. There are many less complications and less dangers if one dissects the gall-bladder from above downwards only after carefully locating the Foramen.

Concluded on page 54

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, April, 1945 No. 4

*War Neuroses**

Baldwin L. Keyes, Lt. Colonel, M. C., U. S. Army

It is a strange fact that with each great world event there tends to develop a vocabulary peculiar to the new experiences and requirements of the men involved.

Many stories of this war have to do with "fox holes" and the use and misuse of them. It is understood that a brave man will prepare and use a fox hole. He is considered wise to imitate the fox well.

Some twenty-five odd years ago that man's father was using what he called a "funk hole," —a hole to crawl into for safety when in a state of "funk"—or fear.

The purpose is the same; the name differs in the light of greater understanding: that fear is normal and protection is wise.

Our psychiatric terminology has been altered also on the basis of greater understanding.

Neurosis is a term at once more clinically descriptive and more applicable to neuropsychiatric battle casualties than the old much misused "shell shock," although both terms intend to describe the same condition.

There are no good figures to compare massive bombings of large cities now and then, since these present more destructive innovations and are so far superior to the old.

It is known, however, that city bombings are far more easily endured than battle bombings, when such figures as more than 40% of casualties from Dunkirk were N. P. cases and only about 15% of casualties in London during the "Blitz" were N. P. cases. This may be due to the very personal nature of a battle attack, with no escape available, while in the big city, the city is the point of attack—it is a little more impersonal and shelter seems more readily available, even if not actually true.

Man learns slowly, but he does learn a little with each quarter century.

More is understood now about psychological mechanisms, and of what goes on in a man's mind, and of what happens in his nervous system under stress.

Symptoms are therefore more adequately interpreted, and principles of treatment are more generally and adequately understood.

Although combat neuropsychiatric cases in recent modern wars have been much the same, there are now many more physicians who are versed in psychiatric interpretations and phraseology, and the syndromes are measured on a far more scientific and technical plane.

* Presented at the 91st Annual Session of the Maine Medical Association, at Rockland, Maine, June 27, 1944.

The experiences in War I, and in the Spanish Civil War, and now in War II, all indicate the principles in causation. The manifestations and the treatments for relief for these conditions are well established on positive grounds, are readily definable, and in most instances promptly curable.

In a discussion of war neuroses it must be recognized that all these neuropsychiatric problems arising in the Armed Forces in wartime are not an index of the number of true war neuroses, but are really an index of the usual neuropsychiatric cases arising in any group of 10,000,000 men anywhere, plus those accounted for by maladjustments to army and navy life.

Actual combat neuroses form a relatively small part of the total group.

So much unfortunate publicity has surrounded the stirring title "battle neurosis" and so much inaccuracy in statistics has been published, that the public has been sadly confused and unduly alarmed through believing that most of the N. P. cases from the services are the result of combat experience.

The factors responsible for the larger number of less dramatic patients from quiet areas are significant an inescapable, even with our improved methods of examination, and selection, and preparation of men for army life. Although these methods are the best so far devised, there is ample opportunity for improvement, particularly in the direction of finding an accurate method to determine just how much stress an apparently well man can stand.

Factors which disturb a new soldier at home stations include briefly, the acceptance of the various requirements of army life, involving chiefly separation from the normal dependencies: his family, job security, and the usual mastery over himself. The resentments resulting from this dislocation from the usual pattern of living, in those who do not adjust well, leads to frustrations, anxieties, depressions, and other evidences of faulty adaptation.

These difficulties may interfere partially, or even wholly, with the necessary submergence of self as an integral part of a large group until the soldier develops a positive identification of himself as a part of his unit, and his unit as a part of him.

A great deal has been done, and more will be done, through improvements in screening and selection methods, and through the use of mental hygiene units in various camp installations, where psychiatrists and psychologists are assisting the men to make these adaptations at once, and before minor manifestations of trouble develop into more serious symptoms of illness.

The combat soldier, in the air or on the ground, usually approaches his most severe ordeals of danger and horror at a time when he is at his lowest level of resistance, by reason of his efforts to reach the forward zone. By this time he is hungry, thirsty, sleepless and exhausted.

The soldier on the ground has had to go through long forced marches, over torn up country while loaded with equipment, having no regular meals, and with the artillery and planes responsible for his plight everlastingly pounding him, and knocking down men here and there about him.

The air-man has little of this type of ordeal, but he has long, anxious, trying hours in a small cramped up position, deliberately riding head-on into flack and fighters which he can see coming at him; while planes near him blow up and disappear, and parts of his own crew and machine get shot up. He has the ever present hazard of fire and explosion and of a fall to earth through that cone of flying steel and the uncertainty of what lies below.

Many of these factors are lessened and protected by careful planning, accurate battle schedules, reliable supply lines, fire control, air superiority, and perhaps most of all the incessant vigilance of the officers for their men.

But war would be a game of simple maneuver if all the enemy might do could be foretold and cancelled in advance.

It is inevitable that every type of combat soldier must endure ordeals which will try his physical and nervous strength to the utmost limit.

A man's satisfactory level of resistance to stress depends somewhat upon his personality adequacy and his character tone, careful conditioning under severe training and strict discipline, and development of good physical and nervous health, and a firm and convinced strength of purpose.

Movement toward war, from the day of induction, carries with it an element of fear.

Fear is normal, and in forward areas, is obvious. To have strength of purpose implies the necessity to control fear.

To control fear satisfactorily it must be recognized and something done about it.

Bravery is a demonstration of well controlled fear, with sufficient adequacy of personality to carry out a purposeful act, which is, at that moment, more important than anything else in the universe.

Some control fear by eliminating the situation responsible for that fear through a plan of action based on training;—that is the technique of a good soldier;—the man who captures a strong point by excellent tactical maneuvering of his troops.

Others change fear to rage or fury and carry out acts of desperation, and though not a very good adjustment, some good may be accomplished by this. An officer who admitted he could scarcely force himself to lead his men toward a machine gun nest, was suddenly infuriated by the audacity of the enemy officer deliberately exposing himself to guide the fire toward this hesitating group. In violent anger the frightened officer dashed headlong at the offending enemy and struck him down with the butt of his gun. This sudden daring action stimulated the whole platoon into a mad charge which exterminated the defending machine gunners.

Still others, with inadequate reactions to fear, will devise means of avoiding the situation, and escape from it without actually running away. These may develop subconscious protections which permit escape without frank admission of failure. Among these are the conversion hysterias and like conditions, or the compromises which become acute anxiety states with frank feelings of guilt.

A few, very few indeed, will turn and openly flee from a fearful situation. Some of these are impulsive and clear quickly. Some may develop more serious anxiety and guilt symptoms later.

As an aid in control of fear it is well that men discuss it freely among themselves. To talk about it, to share it, relieves tensions tremendously and often results in humorous "wise-cracks," rarely at each other, but usually referring to self. An infantryman held up well during several trying ordeals but suffered intensely from fear and was in constant terror that his comrades might discover that he was fearful. He eventually developed a severe anxiety syndrome. During his first struggle to tell his medical officer about it, one of his own very excellent NCO's came past and told another chap almost boastfully how scared he had been all of the past few days. Overhearing this was such a relief to the anxious and ill soldier that he laughed loudly and told everyone of his intense fears and insisted upon going back into the line with the NCO.

This relief of tension and anxiety, by vocal expression at the time of an intense emotional experience, saves the need of secrecy and of embarrassment, and at once does away with a sense of guilt in relation to the feelings of fear.

Actually this is just what the psychiatrist tries later to accomplish for those who have not made a frank expression of their feelings on an open and self-acceptable plane. The doctor later puts the man to sleep and helps him, as he slowly comes through the lower levels of consciousness, to review the recent experience and to accept his resulting emotions more freely and without any sense of guilt about them. This was formerly attempted indifferently and largely experimentally as narco-analysis, but now is carried out with careful techniques and expertly as narco-synthesis and is yielding prompt and excellent results.

It is well to inform soldiers that they can avoid combat neuroses by understanding methods of fear control. With proper instruction and guidance they can be made more adequate than they have been before. It is good mental hygiene not only for the army but for the future. Disciplinary training has taught them to accept suggestions well and they almost do and think automatically those things that are well explained to them.

The importance of adequate leadership cannot be overstressed. Leadership depends upon the character, personality and training of an officer. He must have absolute control over himself and be a strict and impartial disciplinarian. His men must know he is capable, brave, and thoroughly informed. They must feel sure that he will not expose them to fatigue and hazards unnecessarily and that he will share dangers and privations with them; that

he will care for them and assure the supply of food, clothing, shelter and ammunition.

In addition to absolute confidence in the integrity of his leader, it is imperative that the soldier develop a complete identification with his unit. He must feel that he is an integral part of that unit, that he has complete confidence in it and in all of its parts. It is also necessary that he understand his equipment, its excellence above that of the enemy, and that he is thoroughly familiar with all phases of a soldier's job. Through a steadily increasing identification of himself with his unit, with his army, and his country he develops faith in the war and a positive purpose in his function, and he then has a backlog for resistance against adversity.

The soldier's will to fight depends upon quite specific factors, sometimes referred to as morale. This means belief in his mission, certainty that he is well trained, fit and tough, and knows his job; knowledge that his leader is as good a soldier as he is himself, that he too knows his job thoroughly. It also means that he has developed an interdependency and close personal relationship with his comrades as important parts of a perfect machine. He must know that he can tolerate reverses well and can put forth more effort because of them. Success in the immediate endeavor must be of paramount importance to him.

Knowing what goes on in the combat area about him is extremely helpful in correlating his own functions and giving him further knowledge of the reason for what he is doing.

Once satisfactorily through a combat experience, fear becomes less important, confidence in self and outfit is greater, leaders are still more significant, and it all becomes a little easier.

Combat too often, without sufficient time for rest and revitalization, leads to insidious exhaustion, and nervous manifestations begin to show up, even in tough men. Frequent reliefs and replacements when possible are a great economy. But in a moving war this is not always possible. An officer who had been hardy and tough and an excellent combat soldier, after a series of brilliant engagements under exhausting circumstances, began to tremble and shake and sweat and almost burst into tears when sent back for a rest.

Factors which precipitate combat neuroses in a sensitized man may be slight in themselves, and are usually only the exploding spark to a cumulative experience. An excellent NCO in charge of a mortar team withstood quite well a long siege of combat and casualties among his men and later, during a lull in a usual barrage, a shell struck a wall across the street from him. He dropped to his knees and burst into tears and began to run about in a confused state.

Sudden death or serious injury to a close comrade often disturbs a man more than the fear of injury to himself. This tears apart his close personal dependency upon his fellow soldier for whom he also feels responsible and disrupts the small unit of which they both are a part.

A good soldier exhausted by long ordeals after a shell killed his slower moving "buddy" a few feet behind where he had jumped into a ditch, was brought into the aid post shaking violently and sobbing hysterically, crying, "They killed Joe—They killed Joe." When it was discovered that a fragment of the same shell had pierced his own tunic and caused a flesh wound in his back, which he had been too disturbed to notice, he was tremendously relieved. He had shared Joe's danger, and he was no longer guilty of having "let Joe down."

A thoroughly reliable veteran after considerable combat, although fairly exhausted, volunteered to help fresh troops put up barbed wire because he knew the lay of the land. A machine gun opened up, and one of the new lads fell, wounded in the leg, though not seriously. The old soldier stood transfixed in a hysterical trance and had to be led away. He had been responsible and could no longer tolerate the burden.

Again, an officer out with a night raiding party, picked up his corporal, who had a badly wounded knee, and carried him in through heavy machine-gun fire. When he reached the aid post, he was delighted with his success. He laid the lad on a stretcher, then suddenly discovered that the boy was dead, having been hit through the head apparently while in the officer's arms. The officer collapsed to the floor, sobbing violently, and could not be quieted. He felt an overwhelming sense of guilt, even though his uniform on one side had been torn

to shreds, and his escape miraculous, because he too should have been wounded. It took two days of sleep with heavy sedation to quiet him enough to return to duty.

These cases are indicative of the strength of the tie that binds men together and carries them through remarkable experiences successfully.

A long continued exposure to heavy fire when alone and isolated proves a dangerous ordeal to many. Men have been wounded moving across a known field of heavy fire in an effort to reach a companion just to share the danger.

It will be seen that combat neuroses are not the same as civilian neuroses, for they depend upon a different set of background factors for their development, and a different set of immediate factors for their precipitation. There are very few situations in civilian life comparable, although there are some. The gangster wars in our own most peace-loving of all countries have produced occasional like syndromes in hunted and nearly caught men.

The varieties of nervous states which arise in combat and operational experiences may follow almost any pattern, though the most usual are overwhelming emotional outbursts, acute anxiety states with depression and guilt feelings, hysterical conversions, tremors, amnesias, fugues, confusions, and states of apathy. Rarely, acute psychotic episodes with bizarre behavior and schizoid reactions are encountered. Now and then a temporary Parkinsonian like syndrome develops with characteristic facies, posture and tremors.

Late symptoms, and some which occasionally develop a long while after a battle experience are hallucinations, tense restlessness, terrifying battle dreams, and startle reactions even to minor noises and smells.

Treatment of acute war neuroses depends upon the factors which will prevent them and those elements involved in processing and preparing a soldier for battle.

In the handling of acute cases at the source of their occurrence, it was found during the last war that treatment in forward areas saved many to return to the front. The British, in 1916, established the first neuropsychiatric treatment units in the casualty clearing stations just behind the lines. The method then was largely one of deep sedation for several days, followed by positive suggestion and prompt return to duty in the combat area. The results were far better than earlier, but not too satisfying. During the Spanish civil war similar efforts were attempted.

Now the techniques are far more complete, and the results much more promising. The principle of keeping the man in a forward area is proving again and again to be most sound. The further to the rear he goes, the less possibility of return to combat and the more likely is his neurosis to remain fixed. In the average case, of not too great intensity, three to four days of fairly deep sleep with any available sedation, preferably sodium amytal or nembutal, gives the man a much needed rest, a relief from all symptoms, and removes him from the precipitating cause of his illness. He is not rendered stuporous for he must be aroused to take nourishment and empty his bowels and bladder. As the narcosis recedes, he is promptly started on following the normal régime of a soldier, making his own bed, lining up for meals, cleaning his shoes, drilling and serving on ward details. In a few days he either returns to his duty or if not quite secure enough, to another job in the forward zone.

If his symptoms are of sufficient severity to demand that he proceed toward the base, his treatment becomes more elaborate. He is evaluated at the evacuation hospital and he is either sent back further or given a narcosis or a narcosynthesis, kept there for a week or ten days of additional care, and returned to duty.

If his symptoms require that he proceed to the base he goes either to a general hospital to be sent home or to a special treatment center if thought to be quickly recoverable.

In such a special treatment center he is told as he goes in that he has been selected for this treatment program because he is recoverable and is expected to return to duty with his division within six weeks. He is put through the usual preliminary studies quickly on the first day, and then submits to a four- or five-day narcosis. This is followed by four or five days of sub-shock insulin, during which he is gradually put in contact with his new surroundings and begins to look after himself, so that by the end of this insulin period he is again following the soldier's routine. Each week thereafter

Continued on page 66

The Sulfonamides in Ophthalmology

Howard F. Hill, M. D., Waterville, Maine

The sulfonamide compounds have proved to be the most important addition to ophthalmological therapeutics in the last twenty-five years.

Even so, it is equally important that they should not be used indiscriminately or be considered a panacea. The sulfonamides should not be used orally without careful checking of blood and urine before starting therapy and at frequent intervals during the course of treatment. They should never be used for minor conditions that would respond satisfactorily to simple methods, not only because of the definite danger involved in their use, but also because of the possible sensitizing of a patient to a drug that might be needed later for a more serious ailment.

Experimental work[1, 2] has indicated that some of the molds, penicillin, gramiciden, etc., may be of even greater therapeutic value in certain ophthalmological problems to be discussed here, but these will not be reviewed at this time.

The sulfonamide derivatives are used both orally and topically in the treatment of ocular infections. Of the original group including azosulfamide, sulfanilamide, sulfapyridrine, sulfathiazole and sulfadiazine, all have been virtually discarded excepting sulfanilamide, sulfathiazole and sulfadiazine. While the first has the advantage of greatest solubility throughout the ocular tissues it has the disadvantage of a much greater toxicity, and of relatively lesser activity against such organisms as the pneumococcus and staphlococcus. Of the latter two, sulfadiazine appears to have a slight advantage with oral use because of its lower toxicity, and is the drug of choice for the more common infections.

The sulfonamide compounds are used locally in solution, powder, ointment, paste, or in emulsion form. Sulfanilamide can be used in .8% concentration, and sulfathiazole and sulfadiazine in 5.% concentrations of their sodium salts because of their low solubility.

For use on the lid margins emulsions are excellent. For the conjunctiva and cornea, because of the rapid dilation with tears, a grease base ointment which holds the drug longer in contact has an advantage. With hospital use the powder is best as it can be dusted on every three or four hours. Solutions are rapidly washed away and are therefore less effective.

Patients should be kept out of the sun during treatment to avoid photosensitization.

A basic knowledge of drug penetration of the tissues involved is essential if proper results are to be obtained. These drugs vary in their penetrating ability to the various structures of the eye, both with oral and topical therapy. Sulfanilamide[3] gives the highest concentration in the eyeball both by the oral and local route, and adequate therapeutic concentration is obtained. Sulfathiazole gives only average of 18.4% of the blood level in the intraocular fluids.[4] This might lead to the conclusion that this very valuable compound is contraindicated in ocular infections. But it has been demonstrated[5] repeatedly that infection and inflammation of the ocular tissues increases the concentration of the drug in the aqueous. This increase is in direct proportion to the severity of the infection. In severe fulminating infection of the globe, as high as 91% of the blood concentration has been reported by various workers. With a moderate corneal ulcer, up to 46% of blood level has been found. The intraocular fluids are similar in origin and chemical structure to the spinal fluid, and it has been found, experimentally, that the concentration of sulfathiazole in the normal spinal fluid is only a fraction of the blood level. But with inflamed meninges, such as in acute meningitis, the concentration is greatly increased to adequate chemotherapeutic levels. Heat systematically and locally applied markedly increase the concentration within the eyeball.

Paracentesis of the anterior chamber will also rapidly raise the concentration and increase the effectiveness of the sulfonamide used.

Local use of the sulfonamide compounds with the one exception of sulfanilamide does not give adequate therapeutic penetration through the cornea and sclera unless special techniques are used.

Iontophoresis has been used successfully in experimental work by von Sallman[1, 2] and Boyd,[5] in increasing the aqueous concentration, but the method is complicated for general clinical use[4] and requires the coöperation of the patient to a degree that is impracticable with children and some adults.

Experimental work[6] with various wetting agents has shown that the local penetration of the sulfonamides can be increased to more than adequate chemotherapeutic concentration in the anterior chamber. This was especially noted with sulfathiazole and sulfadiazine, the most commonly used of the sulfonamides at present in ophthalmology. These wetting agents act by increasing the permeability of the cornea and sclera and are mixed with the sulfonamide to be used. One of the best of these agents is aerosol O. S. (.2% to 1%). Zephiram has been used with much less effect. These can be used also to increase the penetrating properties of other ocular drugs such as the mydriatics and myotics.

Experimentally by increasing the strength of the wetting agents, penetration of the sulfonamides could be increased up to saturation. As high as a 10% solution of aerosol O. S. has been used in rabbits' eyes resulting in cloudy corneas which cleared up in twenty-four hours without apparent injury. Up to 2% aerosol O. S. caused no irritation. .5% used clinically is sufficient for therapeutic use.

Heat, either systematically or locally applied markedly increases the penetration of the sulfonamides, in topical application.

Anterior chamber concentration with help of the wetting agents is higher than can be obtained by oral administration alone. Wetting agents may increase the local penetration ten to twenty times. But penetration to the deeper structures beyond the anterior chamber is not obtained by any topical therapy. Therefore oral therapy is necessary with infection involving the posterior segment of the eyeball.

Also oral therapy is not adequate in anterior segment infection but may aid by penetrating the adjacent tissues which are often involved.

In local therapy one must remember that the action of the sulfonamides is inhibited by serous or purulent material and any such accumulations should be carefully washed away before local applications are attempted.

Local anesthetics also inhibit the action of the sulfonamides.

The opthalmic infections favorably affected by the sulfonamides include the following:—

a. *Trachoma.* Although considered a virus disease, this is reported[7] to be cured or arrested in a large percentage of cases. It should be used orally, and the usual local treatment with silver and copper salts carried on. It has no value locally, according to most workers.

b. *Inclusion blenorrhea.*[7] This is also a virus disease, and like trachoma, due to one of the larger viruses, and responds very well to the sulfonamides. Local therapy is sufficient with a 5% ointment in the treatment of infants, but oral therapy is necessary in adults.

c. *Gonorrheal ophthalmia.* Sulfathiazole or sulfadiazine given orally in doses sufficient to maintain a blood level of 10 mgs. % in infants and adults alike, gives excellent results. In addition local use with sulfadiazine plus wetting agents, increases the effectiveness. The only other treatment needed is postural drainage and irrigation. Cure in one week is usual if uncomplicated. The results obtained in ocular gonorrhea are substantially superior to those reported in the urethral infection, probably due to anatomical reasons that chronic ocular gonorrhea is a rarity. No cases of ocular gonorrhea have been reported as resistant to the sulfonamides, with the exception[8] of two cases that were resistant to sulfanilamide, but responsive to sulfapyridine. In metatastic gonorrheal iritis, oral therapy seems to promise considerable improvement over previous forms of medication.

d. *Staphlococcus infections of the eye.* These are the most frequent of all ocular infections. Marginal ulcers are common. This bacteria is more resistant to the sulfonamides, but sulfathiazole in high concentration gives excellent results. However, with intraocular infection treatment should include staphlococcus antitoxin and fever therapy. The ulcers may be treated with sulfadiazine powder every four to six hours. Staphlocuccus blepharitis is a disease of the lid margins and responds very well to sulfathiazole or sulfadiazine 5% ointment, combined with injections of staphlococcus toxoid.

e. *Catarrhal conjunctivitis.*[9] This is probably caused by streptococcus viridans and responds well to 5% sulfathiazole ointment.

f. *Influenza bacillus conjunctivitis, dacryocystitis,* and (rarely) *orbital cellulitis.* The conjunctivitis responds well to 5% sulfathiazole ointment. The sulfonamides orally are recommended for the deeper infections.

g. *Colon bacillus conjunctivitis.* This is very susceptible to the use of the powder and ointment forms of the sulfonamide.

h. *Actinomycosis infection of the lids and orbit.*[10] This is reported to be favorably affected by the sulfonamides.

i. *Serpent ulcers.* These are usually caused by the pneumococcus, rarely by the Morax-Axenfeld bacillus and bacillus pyocyanus. These bacteria are all sensitive to sulfathiazole and sulfadiazine. Therapy must be both oral and local, and combined with the usual local treatment. Good results may be expected only if treatment is early.

j. *Cellulitis of the lids and orbit.* The sulfonamides are a definite aid when combined with the usual drainage.

k. *Early post operative wound infection.* Oral and local sulfonamide therapy is extremely valuable.

l. *Panophthalmitis* and *endophthalmitis.* These are purulent infections and sulfonamide therapy must be used early to achieve satisfactory results. Oral administration in adequate dosage, and local therapy with wetting agents should be used. Good results have been reported.

m. *Sympathetic Ophthalmia.* Results of sulfonamide therapy in sympathetic ophthalmia have been very disappointing with a few occasional dramatic cures. Recently the writer has had one case of severe posterior segment involvement of the sympathizing eye, with rapid recovery to 20/20 vision within three weeks, following intensive therapy with sulfadiazine, although this had to be discontinued at the end of one week with a blood level of only 11 mgs. % because of a very severe general toxic reaction. The drug should be used in large doses, giving if possible, an early blood level of 15 mgs. %. With anterior segment involvement, local therapy with wetting agents should be used.

Cases have been reported of anterior chamber contamination that have had anterior chamber irrigations with a 10% sodium sulfadiazine with no irritation or untoward results.

A. Woods[11] has reported a large series of cataract extractions with small doses of sulfadiazine used prophylactically. This series showed a marked decrease in post-operative uveitis and post-operative infection (7% to 1.3%). The writer has used this procedure in cases in which infection was suspected. This seems a logical technique to use in penetrating injuries to the globe with possible infection.

In acute purulent conjunctivitis, due to pneumococcus, Kock-Weeks bacillus or staphlococcus, the results of sulfa therapy are generally unsatisfactory. Oral administration is reported to shorten the course of the disease, but unless the infection is superimposed upon a recent operative wound or trephine bleb such radical therapy is not indicated in such a self limited disease.

In non-specific chronic uveitis the sulfonamides appear to be of little or no value. Likewise brucellosis, tularemia and pemphigus are probably not susceptible to chemotherapy.

Ocular toxic manifestations[12] from oral therapy with the sulfonamides are sometimes seen. The most common symptom is transient myopia. This is thought to be due to changes in the lens as the myopia is unaffected by mydriatics. Paresis of the accommodation[13] is the next in frequency. Other reported complications are retinal hemorrhage,[14] optic neuritis,[15] scleral congestion,[16, 17] yellow sclera, cells in the aqueous, cataract, edema of the retina, reduction of visual fields and varied refractive changes.

Topical administration of the sulfonamides may cause chemosis of the conjunctiva and lid edema. The writer has had one case of severe superficial keratitis following such therapy.

Berens[18] and Bellows[4] have reported that the sulfonamide compounds have an unfavorable effect upon the activity of regenerating epithelium, increasing the healing time to twice that required by the controls. They also tend to increase the formation of scar tissue. There-

fore their use should be avoided in non-infected wounds and abrasions of the corneal epithelium, and after removal of foreign bodies.

Summary

1. The sulfonamide derivatives are most important additions to ocular therapy, but must not be used indiscriminately for minor infections which do not warrant the risk of toxic reactions; nor should they be considered a panacea.

2. This group of drugs when given should be used in adequate dosage, and the patient checked carefully and frequently for toxic reactions. With oral therapy, one must watch for ocular symptoms of general toxicity.

3. Posterior segment infection is affected only by oral therapy. Its effectiveness is increased by heat and by the intensity of the ocular infection.

Anterior segment infection requires topical administration of the sulfonamide. Oral therapy is also of value when indicated, by penetration of the adjacent ocular structures, which are often involved.

4. With topical therapy in infection of the anterior segment of the globe, it is necessary to increase the local penetration through the cornea and sclera by special technique such as the use of heat, paracentesis, wetting agents, etc. Properly carried out, this will give adequate chemotherapeutic concentration in the anterior segment.

5. The topical action of the sulfonamide derivatives is inhibited by secretions, debris, and by the use of local anesthetics.

6. The sulfonamide compounds used topically retards the normal growth of epithelium and promotes scarring. These should not be used on uninfected superficial corneal wounds.

7. Oral therapy of the drug may be used prophylactically in suspected wound contamination of the globe.

8. The following ocular infections are favorably affected by the sulfonamides:—trachoma, inclusion blenorrhea, catarrhal conjunctivitis, staphlococcus infections, influenza bacillus infection, colon bacillus infection, actinomycosis infection, serpent ulcers, cellulitis of the lids and orbit, endophthalmitis, panophthalmitis, gonorrheal infections, and occasionally sympathetic ophthalmia.

References

1. Penicillin and Sulfadiazine in the Treatment of Intraocular Infection. Vol. 30, p. 426, *Arch. Ophth.*, Oct., 1943.
2. Penicillin and Sulfadiazine in the Treatment of Experimental Infections with Staphlococcus Aureus and Clostridium Welchii. *Arch. Ophthal.*, Vol. 31:54, Jan., 1944.
3. Bellows, J., Corneal Penetration of Sulfanilamide and some of its Derivatives. *Arch. Ophthal.*, 27-997, May, 1942.
4. Bellows, J., Chemotherapy in Ophthalmology. *Tr. Am. Acad. Ophthal.*, Vol. 47:19, 1942.
5. Boyd, J., Sodium Sulfathiazole Iontophoresis. *Arch. Ophth.*, Vol. 28, p. 205, Aug., 1942.
6. Bellows, J., Application of Wetting Agents in Ophthalmology. *Arch. Ophthal.*, Vol. 30, p. 352, Sept., 1943.
7. Thygeson, P., Sulfonamide Compounds in Treatment of Ocular Infections. *Arch. Ophthal.*, Vol. 29, p. 1000, June, 1943.
8. Greyton, J. S., and Woods, A., Use of Sulfonamide in Ophthalmology. *Am. Jour. Ophthal.*, 24:428, 1941.
9. Thygeson, P., and Braley, A. C., Local Therapy of Catarrhal Conjunctivitis with Sulfonamide Compounds. *Arch. Opthal.*, Vol. 29, p. 760, May, 1943.
10. Cutting, W. S., and Gebhardt, L. P., Inhibiting Effects of Sulfonamides in Cultures of Actenomyses Hormones. *Science*, 94:568, 1941.
11. Woods, A., and Gayton, J. S., Prophylactic Sulfadiazine for Cataract Extractions. *Am. Jour. Ophthal*, Vol. 26, p. 1278, Dec., 1943.
12. Bellows, J., Local Toxic Effects of Sulfanilamide and Some of its Derivatives. *Arch. Ophth.*, Vol. 30:65, July, 1943.
13. Laval, J., Paresis of Accommodation after Sulfadiazine Therapy. *Amer. Jour. Ophthal.*, Ser. 3, Vol. 26, p. 303, March, 1943.
14. Goar, E. L., Retinal Hemorrhages Following Use of Sulfathiazole. *Amer. Jour. Ophthal.*, Ser. 3, Vol. 25, p. 332, March, 1942.
15. Buey, P. C., Toxic Optic Neuritis Resulting from Sulfanilamide. *J. A. M. A.*, 109, p. 1007, Sept. 25, 1937.
16. Alvaro, M. D., Effects Other Than Acute Infections of Sulfonamide Compounds on the Eye. *Arch. Ophthal.*, Vol. 29, p. 615, April, 1943.
17. Havaland, J. W., Skin, Conjunctival and Scleral Reactions in Course of Therapy with Sulfathiazole. *Bul. John Hopkins Hosp.*, 66:313, 1940.
18. Berens, C., deGara, P., Lontfallul, M., Effect of Sulfonamide Ointment on Healing of Experimental Wounds of the Rabbit Cornea. *Arch. Ophthal.*, Vol. 30, p. 631, Nov., 1943.

Continued on page 71

Editorials

Important Drugs in 1910-1945 Reflect Progress in Medicine

The great advancements which medical science has effected in the treatment of disease during the past 35 years are reflected in what physicians consider to be the most important drugs today as compared with those used in 1910, *The Journal of the American Medical Association* for March 10 points out in an editorial. *The Journal* says:

"Physicians, listing the ten most important drugs used in medicine in 1910, chose them in the following order: (1) ether, (2) morphine, (3) digitalis, (4) diphtheria antitoxin, (5) smallpox vaccine, (6) iron, (7) quinine, (8) iodine, (9) alcohol, and (10) mercury. Just five years previously the Council on Pharmacy and Chemistry [of the American Medical Association] had been established to eliminate from medicine the shotgun therapy [treatment] based on indiscriminate empirical remedies. Out of their efforts came such works as Useful Drugs. The same impetus brought about intensive revision of the United States Pharmacopeia, which today, along with Useful Drugs and New and Nonofficial Remedies, may be said to constitute the proved armamentarium of the physician.

"Tremendous advancement has occurred in the field of therapy since 1910—so great indeed that it is almost impossible to list today ten individual remedies which might be said to be the ten most important or useful in medical practice. In an effort to determine what leaders in medicine might choose as most important in 1945 the editor of *The Journal* addressed a communication to some of the professors of medicine in leading medical schools. The largest number of replies put penicillin first. In considering penicillin, however, other antibiotic [life-destroying] drugs were added. Certainly the sulfonamides come exceedingly close from the point of view of their application under a wide variety of circumstances. At least five of the physicians consulted placed morphine first on the list of important drugs, yet many added to morphine the names of some of the barbituric acid derivatives. Ether still merits a place on any list of important drugs, but today the anesthetist has access to nitrous oxide-oxygen, cyclopropane, ethylene, local anesthesia, spinal anesthesia and continuous caudal anesthesia as well as the basal anesthetics injected directly into the blood. Digitalis still holds a place among the most important of remedies. The diphtheria antitoxin of 1910 is now supplemented by innumerable antitoxins and vaccines established as specific against certain infections. New on the modern list are blood plasma, whole blood for transfusions, gamma globulin and all of the other substances derived from blood. Little was known in 1910 of the products of glands. Today the life-saving properties of insulin, liver extract, estrogenic and male sex hormones, adrenal and thyroid are unquestioned. Little was said in 1910 about vitamins, but the vitamins must be included in any significant list because of their specific virtues in cases of established deficiencies such as rickets, scurvy, pellagra and beriberi. Questionable on any modern list would be the arsphenamines. If penicillin develops as is anticipated in the treatment of syphilis, the arsphenamines may go far down on any list of important remedies. Since malaria appears to be the most widespread of all diseases on the face of the earth, the quinine of previous generations must be assisted by quinacrine and other specific antimalarial remedies.

"A 1945 list of the most important remedies might be:

"1. Penicillin and the sulfonamides and antibiotics.

"2. Whole blood, blood plasma and blood derivatives.

"3. Quinine and quinacrine [a synthetic substitute for quinine also known as atabrine].

"4. Ether and other anesthetics, morphine, cocaine and the barbituric acid derivatives.

"5. Digitalis.

"6. Arsphenamines.

"7. Immunizing agents and specific antitoxins and vaccines.

"8. Insulin and liver extract.

"9. Other hormones.

"10. Vitamins.

"Physicians of long experience will arise at once to defend iron, iodine, alcohol, mercury, and even aspirin. Actually the choice of the most important remedy depends on the condition with which the physician is confronted. For malaria there is no question about the value of quinine or quinacrine; for asthma, epinephrine or aminophylline would seem most important. For amebic dysentery emetine, chiniofon or carbarsone would be the choice. If the patient just happened to have postprandial [after a meal] indigestion, baking soda might be considered the sovereign remedy. One of the experts put common table salt as number 4 on his list and glucose as number 5.

"So great then has been the advancement of therapy that the choice of the ten most important remedies in medicine would baffle any assemblage of experts. The physical therapists might well question the entire list. The surgeons and authorities in the field of cancer would have ideas seriously varying from those of the internists. All physicians may well take great pride in all that medicine has accomplished in the past quarter century!"

Journal Urges Support of Bill for Medical Student Deferment

Medical schools and medical societies should give full and active support to the principal provisions of a bill introduced in Congress by Senator Ellender, which provides for the deferment of premedical and medical students, *The Journal of the American Medical Association* for March 10 urges in an editorial. *The Journal* states:

"The Council on Medical Education and Hospitals [of the American Medical Association] has repeatedly urged the necessity for changes in the present policies of governmental agencies, including the Selective Service System, having to do with the education of premedical students. The regulations now in force threaten either a reduction in Freshmen enrollments or a far poorer quality of students in late 1945 and 1946. The House of Delegates of the American Medical Association at its meeting in Chicago in June, 1944, took official cognizance of the seriousness of this problem and addressed communications to the President, to the War and Navy departments and to the Selective Service System urging that immediate steps be taken to remedy the situation.

"Now official notice of this threat to medical education and medical standards has been taken by Senator Allen J. Ellender of Louisiana, who introduced on February 26, Senate Bill 637, which has been referred to the Committee on Military Affairs. The bill includes provisions for the deferment of adequate numbers of premedical students for a period of two years and further provides for the deferment of such numbers of medical students as will be sufficient to supplement civilian sources of students for the maintenance of full classes. The bill also calls for the return to medical and premedical studies of qualified members of the armed forces who have honorably served for a year in the military forces. The latter provision may require some clarification, especially as regards the selection of students for this type of training.

"At the time of introducing his bill, Senator Ellender pointed out that the discontinuance of the Army Specialized Training Program and the Navy V-12 Programs would, with a few exceptions, result in the cessation of the admission of new students to the Freshmen classes of 1945 in the medical and dental schools. This is a manpower problem of the present moment, he said, only because a critical shortage of doctors and dentists after 1948 must be anticipated and can be prevented only by action taken now, before September, 1945. The army and navy medical corps are certain to need more physicians after the war than were required before this war started; the Veterans' Administration

will demand eight or ten thousand doctors; physicians will be required to administer the features of the compulsory military training program if that should be provided by Congress and an unknown number of doctors may be wanted to provide the most basic needs of the now occupied countries of Europe, where no medical education has been possible for five or more years. All these requirements are likely to result in a greater deficit of medical men than ever before. The profession is being depleted by about four thousand deaths and an unknown number of retirements annually, Senator Ellender said, and this picture will add up to a very serious situation unless a continuous flow of medical student graduations is maintained annually.

"The introduction of this bill represents a great step forward toward the objectives of continued medical education and adequate training of qualified young men. The main outlines of this bill are fully endorsed by the Council on Medical Education and Hospitals of the American Medical Association and the Executive Council of the Association of American Medical Colleges, both of which took part in several conferences on the proposals embodied in the bill with a representative of Senator Ellender. Both medical groups will doubtless participate in the hearings to be held on this bill, the principal provisions of which should receive the full and active support of medical schools and medical societies everywhere."

War Neuroses—Continued from page 59

calisthenics, drills, and other activities are increased, until about the fifth week he is taking five-mile hikes with full equipment; and at the end of the period he is sent out of the hospital, not in an ambulance, but in the usual convoy troop carrier, completely re-equipped, including rifle, gas mask, and other acoutrements. Throughout his stay in the hospital he is faced with the positive suggestion of getting well and returning to duty.

From the second week onward he attends group psychotherapy sessions in which soldiers are given talks by a medical officer, a psychiatrist, who leads them into discussions. These group psycho-therapy periods inform the soldier of the nature of his illness, what can be done to prevent it, and it is demonstrated to him how he is definitely getting well. The average soldier enters into these discussions readily, and on the whole very intelligently, and before many days he begins to feel at ease with the group with which he is associated, and again develops the sense of group security to which he is accustomed, so that when he goes out of the hospital he is ready to continue once more on an equal level with his fellows.

The results from this form of treatment have been startlingly satisfactory with the return to the original unit of possibly 60% of the men so processed. All those who do not recover promptly, or who have been too ill to be considered for this treatment, are returned to the zone of interior for longer measures of care, some for treatment and some for discharge.

The neuropsychiatric casualties that are coming back into civil life only form a serious problem in rehabilitation because they have been so much misunderstood. Well meaning, but oversympathetic prolonged adulation would tend to fix more deeply some of their existing insecurities, and may mean greater disability and larger pensions in the future.

Many of these patients who are no longer suitable for the specialized requirements of the army, are even so in better condition for industrial employment than many who have not had army experience. It is important for the public to recognize that most of these men are quite ready to be absorbed in a useful capacity and must quickly feel the security of again earning a living.

The family doctor is going to be the medium through which these men return satisfactorily to a civilian status. The patient will come back to his doctor discouraged and perhaps overwhelmed with his efforts to adjust to another change in his mode of living, and to reestablish himself in an earning capacity. He must be understood, encouraged, and yet handled with firmness, and be made to feel his responsibility in becoming again a significant part of his home community.

Necrologies

Roger Paul Jordan

Gustav Adolph Pudor, M. D., 1864-1945

Dr. G. A. Pudor, who died March 7, 1945, was born in Portland, August 31, 1864, as the youngest son of Dr. Christian Ferdinand Pudor and his wife, Lucia Amalia deFries. His father having died when the boy was barely 6 years old his education was carefully guided by his mother, the much older sons having left Portland to go into business in larger places. He went through the public schools and after graduating from Portland High entered Harvard College in 1882 in company with his special friends, LeRoy Hight and Ernest Oxnard, graduating in 1886 summa cum. Followed a summer trip with his mother and chum Oxnard to Europe. After return from this vacation, he entered Harvard Medical School and gained his Doctorate. Two years of study in Berlin University followed where in the latter part he had a severe attack of the then rampant influenza which nearly cost him his life as he insisted on continuing his studies until he broke down and only complete and protracted rest in the quietest of quiet small towns gave him back to life. Before returning to America, mother and son took an extended tour through southern Germany and Switzerland. So it was in 1890 that the young doctor hung out his shingle at the door where his father's name had not been taken away in all these years after his death. Practice was slow in coming and had it come faster it would have interfered sorely with the loving devotion which the son gave to his beloved mother in her illness which lasted nearly four years. January, 1895, brought the death of Mrs. Pudor and on March the 7th only 3 months later, Mr. Cornelius P. who had come home for the mother's funeral died suddenly from heart failure. Dr. Pudor then got the City physicianship which he held for 2 years. In the meanwhile, he had decided to go into special work of Dermatology and in order to prepare himself fully for this new field went again to Europe for study. He was greatly appreciated by the different capacities at whose clinics he worked unremittingly and had several offers to stay and work as their special assistant, but he declined. That summer he married Fraulein Margarete Besig, but as he wished first to get a footing in the, for

Maine, new field of Dermatology, he returned alone to America, leaving his young bride to follow him six months later.

Gradually this new work started and succeeded. Being house doctor for a few years at the Maine School for the Deaf helped out the, at first, so slender income. Then Dr. Weeks brought the good news that Dr. Pudor had been elected for the new chair of Dermatology at the Bowdoin Medical School which he occupied until this part of Bowdoin College was closed out for lack of funds. During this time the young Professor gained love and admiration from his students both for his excellent teaching and human and humorous approach.

During the first World War he served as Captain in the Base Hospital at Camp Devens until for health's sake he had to give it up April 1, 1918.

He was on the staff of the Maine General and Children's Hospital until age limit retired him. The V. D. Clinic of the Portland Dispensary was his special pet and he devoted long years of intense work to it at times even when his own health should have demanded that he give it up.

January, 1941, a second attack of influenza forced Dr. Pudor to retire from practice absolutely and he never regained full health again.

The Foregoing detailed account of Doctor Pudor's life, kindly supplied by his widow, indicates with what degree of thoroughness he prepared himself for his life's work as a Dermatologist. The "capacities" as employed by Mrs. Pudor means such world renowned authorities as Hadra, Lassar and Joseph.

However, Doctor Pudor was much more than a Dermatologist. He was a lovable human being. To a remarkable degree he always displayed that old-fashioned courtesy which makes one shrink from ever uttering a word that might wound the feelings of a brother practitioner. He was a modest man who carried his honors lightly; an honest man who spoke candidly; a friendly man who really was interested in his neighbors, his associates and his patients; a truly Christian gentleman, who, without professing any particular piety, exemplified in his daily life his faith and convictions that "it is better to give than to receive." To quote Osler, Doctor Pudor brought to the practice of medicine "the philosophy of hard work, the philosophy which insists that we are here, not to get all we can out of the life about us, but to see how much we can add to it."

For years I roomed with him as together we attended sessions of the American College of Physicians where, among a host of friends and acquaintances he was affectionately addressed as "Gus." These were Red Letter Days for me. Wherever we appeared, there soon developed, through his charm of manner, his sincere cordiality, a camaraderie that was good to behold. Here was a nature "sloping toward the southern side," as Lowell put it, which made and kept friends and patients for the good doctor.

Early in life he learned that "temporal salvation depends on good food, abundant rest and cheerfulness." That he had attained in full measure. Ere this he must have heard the words "good and faithful servant."

E. W. Gehring.

Eben H. Bennet, M. D., 1848-1944

Eben H. Bennet, M. D., Lubec, a Past President and Honorary Member of the Maine Medical Association, died August 31, 1944.

Doctor Bennet was born in Alberta, N. B., in 1848, the son of Josiah and Annie Olson Bennet. He received his degree in medicine from the Jefferson Medical College in 1875. He was a member of the Washington County Medical Society, the Maine Medical Association and the American Medical Association. Doctor Bennet was President of the State Association in 1910-1911, and was presented with the Association's Fifty-Year Service Medal in 1931, being one of the first to be so honored.

Sumner C. Pattee, M. D., 1876-1944

Sumner C. Pattee, M. D., 68, Belfast, a veteran of World War I, died December 29, 1944.

Doctor Pattee was a native of Belfast. He was graduated from Belfast High School, Bowdoin College, and received his degree in medicine from the University of Pennsylvania in 1903.

During World War I he was a Captain in the U. S. Army Medical Corps and was with the Army of Occupation in Germany. He returned to this country with the rank of Major.

Doctor Pattee was a member of the Waldo County Medical Society, the Maine Medical Association and the American Medical Association.

His widow, Mrs. Lillian M. Pattee, survives him.

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Albert W. Moulton, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

100% Paid Membership for 1945

Piscataquis County Medical Society
Franklin County Medical Society
Hancock County Medical Society
Washington County Medical Society
Somerset County Medical Society
Cumberland County Medical Society

Hancock

A regular meeting of the Hancock County Medical Association was held at the Hancock House, Ellsworth, Maine, on March 14, 1945, at 6.30 P. M.

The President, Phillip L. Gray, M. D., presided at a short business meeting.

Harry Kopfman, M. D., of Deer Isle, spoke on *Socialized Medicine in Europe,* most particularly in Germany.

J. H. Crowe, M. D.,
Secretary.

Kennebec

A meeting of the Kennebec County Medical Association was held at the Worster House, Hallowell, Maine, on February 15, 1945.

Following dinner, which was served at 6.00 P. M., there was a short business meeting in charge of the President, Dr. T. C. McCoy. The Secretary read the minutes of the annual meeting held at the State Hospital in Augusta. The President reported on a meeting of the council and tried to get an expression of opinion as to where to hold the next meeting and as to whom to get as a speaker — also as to the frequency of the meetings. On motion, duly seconded, it was voted to leave the matter of time, place and speaker for future meetings up to the Council.

The President, Dr. McCoy, then explained the absence of Dr. Blynn O. Goodrich of Waterville, who was to be the principal speaker of the evening, as being due to illness.

Dr. McCoy spoke briefly on the use of Penicillin then called upon the individual members of the Society to give their experiences in the use of this drug. They responded well and in the response many valuable points were brought out.

There were thirty members present.

Clair S. Bauman, M. D.,
Secretary.

Piscataquis

On February 15, 1945, there was a meeting of the Piscataquis County Medical Society at the home of E. D. Merrill, M. D., Dover-Foxcroft, Maine. The meeting was called to order at 4.30 P. M., by President Carde. Minutes of the previous meeting were read and approved. There was no new or old business to present. Current Problems were discussed by the members present. It was voted to hold the next meeting at the Blethen House on the third Thursday or Friday of May.

Members present were Drs. Carde, Valentine, McDougal, Brown, Merrill and Bundy.

H. C. Bundy, M. D.,
Secretary.

Notices

Doctors Look Ahead

"Doctors Look Ahead," a series of dramatized episodes devoted to medical progress and research at home and abroad, is presented by the American Medical Association and the National Broadcasting Company each Saturday at 4.00 P. M., Eastern War Time, unless otherwise announced in local newspapers. (On Saturday, April 24, this program will be broadcast at 2.00 P. M.)

Topics in the series, which began January 6 and will continue through June 30, will be announced weekly in *The Journal of the American Medical Association.*

The broadcast is under the supervision of the American Medical Association's Bureau of Health Education, whose director, Dr. W. W. Bauer, will summarize each program except when other speakers are announced.

Massachusetts Medical Society Bureau of Clinical Information

The Massachusetts Medical Society has established a Bureau of Clinical Information at its headquarters, 8 Fenway, Boston, Massachusetts, as a means of augmenting its postgraduate educational effort.

This Bureau will supply information as to the daily activities of the approved hospitals in Boston and its immediate vicinity.

This information will deal with each hospital's schedules of operations for the day, medical and surgical ward rounds, clinics, the location of such clinics and the names of those presiding over these various activities.

From time to time the Bureau will make available a bulletin which will list the fixed medical meetings and conferences held in the metropolitan area. This bulletin will be sent to Hospitals, Medical Schools, and Physicians on request, and will be available at the Bureau. In brief, its ultimate aim will be to serve the profession as a clearing house for all sorts of medical information.

The Bureau will be open from 7.00 a. m. to 10.00 a. m. and from 3.00 p. m to 8.00 p. m. except Saturday afternoons. Information will be given by telephone.

No expense is involved on the part of those using this service.

Walter G. Phippen, M. D.,
Chairman.
Committee on Clinical Information.

Maine General Hospital Medical Grand Rounds

All interested physicians are invited to attend *Medical Grand Rounds*, at the *Maine General Hospital* which are now held at *5.15* each *Thursday afternoon* in the *X-ray Department.*

The Control of Communicable Diseases

The publication of "The Control of Communicable Diseases," an official report of the American Public Health Association, 6th edition, is announced by the Association.

First published in 1916, the successive editions of these standard recommendations for the administrative control of the communicable diseases have had world-wide circulation. The present report is official with the United States Public Health Service, the United States Navy, and has been approved in principle by the Surgeon General of the United States Army.

The present edition contains 72 chapters, of which 20 are new. All the common communicable diseases are included, as well as those less frequently encountered, like the so-called "tropical" diseases.

The book may be secured from the Book Service, American Public Health Association, 1790 Broadway, New York 19, N. Y. It contains 146 pages and sells for 35c per copy and in quantity as follows: 1 to 24 copies—35c each; 25 to 99 copies—30c each; 100 to 499 copies—28c each; 500 up—20c each.

The Sulfonamides in Ophthalmology

Continued from page 63

ADDITIONAL REFERENCES USED

Laval, J., Anterior Chamber Irrigation with Sulfadiazine. *Am. Jour. Ophthal.*, Vol. 27, p. 527, May, 1944.

Thygeson, P., Staphlococcus Blepharitis. *Tr. Am. Acad. Ophth.*, 46:265, 1942.

Thygeson, P., The Treatment of Trachoma with Sulfanilamide. *Am. Jour. Ophth.*, 23:679, 1940.

Sory, R., Sulfanilamide in Trachoma Therapy. *Amer. Jour. Ophthal.*, Ser. 3, Vol. 25, p. 1210, Oct., 1942.

Sweet, L. K., Chemotherapy in Acute Gonococeal Conjunctivitis. *Am. Jour. Ophthal.*, Ser. 3, Vol. 25, p. 1487, Dec., 1942.

Scheie, H., and Leopold, I. H., Penetration of Sulfathiazole into the Eye. Further Studies. *Arch. Ophthal.*, Vol. 27, p. 997, May, 1942.

Heath, P., Graduate Lecture, 1941. *Amer. Acad. Ophthal.*, Course No. 220.

Wong, W., Penicillin and Gramicidin as Ocular Chemotherapeutic Agents. *Arch. Ophthal.*, Vol. 31, p. 165, Feb., 1944.

Bellows, J., and Chinn, H., Corneal Penetration of Sulfonamides. *Arch. Ophthal.*, Vol. 27, p. 34, Jan., 1942.

Martin, W. O., Sulfathiazole Treatment of Parinaud's Conjunctivitis. *Amer. Jour. Ophthal.*, Ser. 3; Vol. 25, p. 1493, Dec., 1942.

Long, P. H., The Clinical Use of Sufanilamide, Sulfapyridine, Sulfathiazole, Sulfaguanidine and Sulfadiazine in the Prophylaxes and Treatment of Infections. *Canad. M. A. J.*, Vol. 44:217, 1941.

Book Reviews

"Modern Clinical Syphilology"
(Third Edition)

By: John H. Stokes, M. D., Prof. of Dermatology and Syphilology, School of Medicine and Graduate School of Medicine, University of Pennsylvania; Director, Institute for the Control of Syphilis, University of Pennsylvania; Herman Beerman, M. D., Sc. D. (Med.), Asst. Prof. of Dermatology and Syphilology, School of Medicine and Graduate School of Medicine, University of Pennsylvania; and Norman R. Ingraham, Jr., M. D., Asst. Prof. of Dermatology and Syphilology, School of Medicine, University of Pennsylvania.

Third Edition, Reset. 1,332 pages with 911 illustrations.

Published by W. B. Saunders Company, Philadelphia and London, 1944. Price, $10.00.

Just as fresh (and readable) as the morning headlines is this new volume on clinical syphilology by the Drs. Stokes, Beerman and Ingraham. A third edition, the publication nevertheless takes on the aspect of an entirely new book in that the authors have revised earlier standard findings and have added results of current clinical experiences.

Not alone have these new "last words" been weaved into type surroundings, but Dr. Stokes and his associates present factual information from military medical men and the U. S. Public Health Service. All of the latest (and successful) treatments including the use of penicillin are given deserving prominence.

The book actually holds the answer to many perplexing questions which confront the average doctor called upon to treat "ugly" cases of syphilis. It is more and more evident that treatment of syphilis is a common medical problem — but here three prominent doctors supply the answers.

"Peripheral Nerve Injuries"

By: Webb Haymaker, Capt., M. C., A. U. S., Neuropathologist, The Army Institute of Pathology, Washington, D. C. (On leave of absence from the University of California, San Francisco and Berkeley); and Barnes Woodhall, Maj., M. C., A. U. S., Chief, Neurosurgical Section, Walter Reed General Hospital, Washington, D. C. (On leave of absence from Duke University, Durham, N. C.)

277 pages with 225 illustrations.

Published by W. B. Saunders Company, Philadelphia and London, 1945. Price, $4.50.

This book was written for the medical officers in the armed forces but it is of great value to medical students and civilian physicians.

It is divided into three sections; the first is an analysis of the segmental and the peripheral nerve supply of skin, muscles and skeleton. The second section is on the examination of the peripheral nervous system; it explains the procedure in the examination of the peripheral nervous system, the examination after

Wyeth

One to One . . .

is the S.M.A. rule: one measure* of S.M.A. Powder to one ounce of warm (previously boiled) water, whatever the quantity desired. It is easy to prepare S.M.A. and it is easy for doctors to tell mothers how to do so.

Because S.M.A. is so closely akin to breast milk babies relish it . . . digest it easily . . . thrive on it. Like breast milk the S.M.A. formula remains constant. Only the quantity need ever be changed. S.M.A. babies are such comfortable babies . . . doctors as well as mothers are grateful for S.M.A.

IT'S EASY TO MIX . . .

S.M.A. is derived from tuberculin-tested cow's milk in which part of the fat is replaced by animal and vegetable fats including biologically assayed cod liver oil; with the addition of milk sugar, vitamins and minerals; altogether forming an antirachitic food. When diluted according to directions, it is *essentially the same as human milk* in percentages of protein, fat, carbohydrates and ash, in chemical constants of the fat and in physical properties.

**One S.M.A. measuring cup enclosed in each 16 oz. can of S.M.A. Powder.*

S. M. A. INFANT FOODS ARE COUNCIL ACCEPTED

Wyeth

S. M. A. DIVISION • WYETH INCORPORATED • PHILADELPHIA 3, PA.

recovery from the acute phase of an injury and the tests employed in the diagnosis or in the prognosis of peripheral nerve injuries. The third section is on the injuries of plexuses and peripheral nerves.

"New and Nonofficial Remedies, 1944"

Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1944. Cloth. Price, postpaid, $1.50. Pp. 778. Chicago: American Medical Association, 1944.

The current volume of "New and Nonofficial Remedies" reflects two important and forward looking decisions of the Council, namely, to use the metric system exclusively in all its publications, and to consider for acceptance contraceptive preparations offered for use as prescribed by physicians. These decisions in turn reflect the vigorous and progressive leadership of the Council in the service of Medicine.

Some of the new preparations that appear in this volume are: Succinylsulfathiazole, a new sulfonamide, a proprietary brand being "Sulfasuxidine;" Diodrast Concentrated Solution, a preparation of the already accepted Diodrast, for use in a special diagnostic procedure for visualization of the circulatory system and also cholangiography; a preparation of Sodium Benzoate for use as a liver function test; Mersalyl and Theophylline, accepted under the name Salyrgan-Theophylline Tablets, proposed as an adjunct to intravenous injection of the already accepted drug; Zinc Insulin Crystals and Zinc Insulin Injection Crystalline; Tetanus Toxoid; and Concentrated Oleovitamin A and D, a dosage of the pharmacopoeial preparation.

A glance at the preface shows that certain general articles have been revised to bring them up to date. More or less important revisions have been made of the following chapters: Barbituric Acid Derivatives, Estrogenic Substances; Parathyroid; Ovaries; Sulfonamide Compounds; Vitamins, especially the sections, Vitamin B Complex and Vitamin D. In this connection it is worth noting that each chapter in the book is reviewed annually, or more often if indicated, by the responsible referee for such revision.

This volume is of paramount interest to all those concerned with rational and modern drug therapy.

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, May, 1945 No. 5

Pudendal Block Anesthesia in Home Obstetrics

Mason Trowbridge, Jr., M. D., Ellsworth, Maine

Careful and deliberate obstetrics in the home is difficult when a semi-anesthetised patient is thrashing about in a pool of amniotic fluid, blood, and vomitus. Most of the inconveniences and all of the hazards of inhalation anesthesia in obstetrics can be avoided by the use of local anesthesia. The hazards of inhalation anesthesia are not great in a modern hospital, but they may loom large in an isolated farm or lumber camp. Often an inept neighbor is called in to give ether, and there are no facilities for combatting the post-partum hemorrhage, aspiration of vomitus, and fetal anoxia that may accompany a general anesthetic. (This is, of course, not a true picture of the average home delivery. Yet, all too frequently one is called to a strange home, there is insufficient time to summon a trained assistant, and catch-as-can obstetrics ensues.)

The many methods of obstetrical anesthesia and analgesia now in use indicate a widespread dissatisfaction with inhalation anesthesia. Some Maine practitioners deliver women in the home with low spinal anesthesia and with conspicuous success. This practice will not be condoned by most physicians. The honeymoon with continuous caudal anesthesia is drawing to a close in many quarters, and this method is certainly not to be recommended for home obstetrics. Heavy barbiturate or scopolamine narcosis may make the patient unmanageable. The use of paravertebral sympathetic block by one of the newer prolonged action local anesthetics is a rational and promising form of anesthesia which lacks many of the disadvantages of caudal. Its general adoption will, of course, have to await further extensive trials.

Local anesthesia has been in use in some obstetrical clinics for more than thirty years. The literature on obstetrical anesthesia shows a steady non-meteoric rise in the popularity of both local infiltration anesthesia of the vulva and levator muscles and of pudendal nerve block anesthesia. The latter is, strictly speaking, a form of regional anesthesia and is accomplished by injecting procaine solution at the point where the pudendal nerve crosses the ischial spine and enters Alcock's canal. Mention of procaine idiosyncracy is conspicuous in the literature by its absence. The danger of needle tract infections appears negligible. Pudendal block anesthesia is now used extensively in both clinic and private practice in the West and Midwest. Textbooks such as recent editions of DeLee and Greenhill[2] and Williams[3] speak with enthusiasm of local anesthesia in

home and hospital obstetrics. In recent years each edition of the "Year Book of Obstetrics and Gynecology" has had several articles on the subject, many of them being followed by vigorous editorial commendation. In the 1943[4] edition the editor (Greenhill) states, "Local infiltration anesthesia is being used more and more widely in obstetrics throughout the world. This is a hopeful sign, because many obstetrical deaths, both maternal and fetal, are directly attributable to anesthetics. It is a pity that more physicians do not avail themselves of this form, which is by far the safest of all anesthetics." It is of interest that of three American articles appearing in 1943 on home obstetrics, two[5] recommend local anesthesia. The third[6] states that fetal mortality will be higher in the home because of lack of oxygen for inhalation. Since fetal anoxia is almost absent in local anesthesia, this might be construed as an argument for its use. The shortcomings of local anesthesia will be mentioned below. But since other methods of relieving pain in home obstetrics leave so much to be desired, local anesthesia should be considered in all home deliveries as well as selected hospital cases.

Procaine infiltration of the perineum alone and the more extensive procedure, pudendal block, both have their exponents. It is my feeling that the latter is superior because of the marked perineal relaxation that occurs only with the nerve block. Urnes and Timerman[7] and Abrams[8] are among the authors who emphasize this relaxation which is a most striking phenomenon. Within five minutes of the injection of procaine there occurs a gaping of the vaginal introitus sufficient to permit introduction of one's fist. Most authors state fewer perineal lacerations will occur with a pudendal block and that the likelihood of an episiotomy being needed is lessened. Philpott[9] states that forceps are rarely necessary when local anesthesia is used at the Royal Victoria Hospital. Rosenfelt[10] has described the external perineal and levator muscles as being "butterlike" after procaine infiltration; it is entirely logical that the fetal head will make more rapid progress against such relaxed muscles than against a spastic perineum. Violent expulsive efforts are absent, and control of the descent of the head is relatively easy when the patient is conscious and not writhing in pain.

Bland and Montgomery[11] and Sheldon[12] consider pudendal block technically difficult. Most authors, however, do not consider it so, and I have found the combination infiltration-pudendal block method of Urnes and Timerman[7] of the Chicago Maternity Center to be eminently satisfactory. These authors " . . . wish to emphasize the simplicity of local anesthesia procedures, especially the pudendal block. We found that inexperienced interns could readily be taught the procedure."

The question of whether pudendal block alone is an adequate anesthesia for routine use is a controversial one. It should be noted that most of the authors questioning the adequacy of local anesthesia are referring to local vulval infiltration and not to pudendal block. As with caudal it is, strictly speaking, a form of "analgesia" rather than "anesthesia." Though perineal pain is abolished, the patient is aware that one is doing an episiotomy or applying traction on forceps. Local anesthesia will not, of course, relieve the abdominal pain of labor, the anesthesia being purely perineal. After pudendal block the patient will continue to groan with low back and abdominal pain but will not scream with the pain of perineal stretching. One primigravida told me that she thought that "her insides were falling out" when delivered with moderately vigorous traction on low forceps. Oddly enough, she regarded this as a novel rather than a distressing sensation. Another primigravida kept saying as a nine-pound infant emerged, "Don't get nervous, doctor." It is hard to evaluate the efficacy of local anesthesia on a small number of patients since some women harbor no resentment against the physician who delivers them with no anesthesia or analgesia in the home. Not all deliveries with pudendal block are as successful as the two noted above. Buxbaum[1] reports that in 40% of the Chicago Maternity Center series of 2,208 cases pudendal block anesthesia was "ideal." In 55% it was "satisfactory" and in 5% "failure." He also states, "Even if the operator elects to use inhalation anesthesia, delivery is definitely facilitated by the addition of pudendal block." There are no complete failures as in caudal anesthesia. Certainly if a responsible attendant is on hand throughout the first stage of labor, moderate barbiturate or other analgesia is indicated. The reaction of the patient

as well as the availability of a trained assistant will determine the advisability of giving a minimal amount of ether or nitrous oxide at the time of delivery.

Variations in the success of the method have been attributed to technical difficulties, but I am inclined to agree with Greenhill[13] that the success is chiefly dependent on the psychological preparation and make-up of the patient. Not all women are good subjects for local anesthesia; among those who are not are those who start clamoring for ether early in labor. One patient compared delivery under pudendal block to having a tooth drilled under procaine anesthesia; "It doesn't hurt, but you are sometimes afraid that it is going to." Thus, pudendal block will not be entirely satisfactory if the physician betrays any misgivings about its success. The patient must have absolute confidence in the physician. Apprehensive patients should not be asked if they wish local anesthesia, but should be told casually that it will be used as an adjuvant, as ideally it should be used, to other forms of analgesia. Fortunately for the success of local anesthesia, patients delivered in the home are less apprehensive and better prepared psychologically than those delivered in the chromium plated atmosphere of the modern delivery room. In my limited experience, the young woman who has not been regaled by too many obstetrical horror stories by elderly women will do very well with pudendal block and 3-6 grains of pentobarbital in any surroundings.

Low forceps delivery is readily performed under pudendal block anesthesia. Abrams[8] states that mid-forceps may be performed with pudendal block, and Sheldon[12] states that mid-forceps and manual rotation of the head is satisfactorily done with adequate perineal infiltration. Version and extraction should not be attempted under pudendal block anesthesia, since no relaxation of the uterus occurs. It is this lack of uterine relaxation that accounts for the decreased blood loss and prompt separation of the placenta in patients delivered with local anesthesia. No increase in the incidence of abnormal fetal presentations has been noted as in caudal anesthesia.

The advantages of perineal procaine anesthesia are most apparent if one is to do an episiotomy or to repair an episiotomy or laceration. Smith[14] condemns vigorously the practice of using general anesthesia for episiotomies and surgical repair of the perineum. In no other branch of surgery, he states, would a patient in such a precarious condition be subjected to a general anesthetic for a procedure that could be done so easily with local. Postpartum hemorrhage and resulting shock are ever present possibilities, and there is unanimity that general anesthesia will increase this hazard. In home or hospital, the physician's peace of mind is greater on this score if he can engage in banter with the patient while doing a leisurely perineal repair. The relative freedom from vomiting with local anesthesia has definite medical and anesthetic advantages.

Greenhill[13] and several other authors contend that wound infections and breakdowns are less frequent with local than with general anesthesia. The usual reason advanced for this is that a more careful and deliberate type of surgery is possible with local anesthesia. If epinephrine is used, the field is relatively dry. Greenhill states that the tissue planes are accentuated by the injected procaine solution, thus permitting a more accurate apposition of wound edges. Philpott[9], however, believes procaine infiltration will make for a slight increase in wound breakdowns. Breakdowns are more frequent if the procaine solution is not isotonic.

Asepsis in the home is not difficult to achieve, but difficult to maintain. It can, however, be rigidly maintained for a few minutes while the block is being performed. After completion of the block, only the ordinary aspetic precautions of a home delivery are necessary. One is naturally hesitant about sinking a 10 cm. needle into any part of the human body, but when doing so in the ischio-rectal fossa the point can be followed at all times by a guiding finger in the rectum or vagina. The point must be followed not only to insure satisfactory anesthesia but to avoid the fetal head. The danger of needle breakage is minimal, for the needle is not in a rigid bony canal as in caudal and spinal anesthesia. The looseness and vascularity of the tissues of the fossa appear to prevent the slough and gangrene that may follow block anesthesia of the fingers or penis where the circulation may be compromised. The amount of procaine used is much less than that used in

many clinics for surgical procedures. There is no likelihood of striking any vital structure in the ischio-rectal fossa.

I do not wish to become embroiled in the controversy as to whether the frequently noted period of apnoea of the infant born to anesthetised and narcotised mothers is dangerous. It does, however, seem desirable to have the infant breathe as quickly as possible in home deliveries. When pudendal block is used, the physician must be quick to remove mucous from the infant's upper respiratory passages lest it inspire almost before the delivery is completed. There is general agreement that when the life of the fetus is jeopardised as in breech presentations, prematurity, and maternal toxemia, local anesthesia is much safer than general.

If epinephrine is used with a 1% procaine solution, the block will last 1-2 hours. Most authors recommend performing it on a primigravida when the perineal muscles begin to bulge, and on a multigravida when there is full dilatation of the cervix. Bunim[15] states that earlier institution of the block may be advantageous in some cases. He reports that pudendal block will permit rapid dilatation of the cervix in cases of cervical dystocia, and that it is indicated in those cases where some might resort to Duhrssen's incisions to hasten delivery. It is recommended in cases of severe maternal exhaustion when progress has been arrested in a prolonged labor by the resistance of a rigid cervical rim. If Bunim's contention is correct, it is not inconceivable that early pudendal block might decrease cervical as well as perineal lacerations.

The decreased number of perineal lacerations and lessened need for episiotomies are definite maternal advantages. Pudendal block is valuable with any poor risk patient where a contraindication to general anesthesia exists, particularly patients with a respiratory infection at the time of delivery.

It should be noted that local anesthesia has a limited value in multiparous patients who will probably precipitate immediately after full cervical dilatation.

One may well ask why, if pudendal block anesthesia is as satisfactory as I have indicated, it has not achieved more popularity. Most writers on this subject express surprise at the unwillingness of the profession to adopt it more widely. One reason for its lack of popularity is that although the complete block can be performed in three to five minutes, the physician must be on hand at the optimal time to do it. On many obstetrical services with experienced nurses, the physician can often manage to arrive just in time to deliver the baby, or the woman may be kept under anesthesia until he arrives. In home obstetrics this is rarely possible or desirable, and the physician might profitably be spending his time waiting for the delivery by doing a pudendal block. He will be well repaid for his efforts by freedom from perineal lacerations, prompt placental separation, and an alert unanesthetised patient whom he can leave without qualms after delivery of the placenta. The technique of pudendal block may seem difficult to one who has not done it a few times to acquire facility. In some patients who seem about to deliver, a delay of 15 minutes may follow the nerve block. With the sudden cessation of perineal pain, the patient will often lose her violent desire to expel the baby. The expulsive efforts will stop unless she is encouraged to bear down. DeLee is of the opinion that local anesthesia is not more popular because we have emphasized complete amnesia during labor to a dangerous degree. It has been stated that local anesthesia is not more widely used because of the inertia which passes in some circles as wholesome obstetrical conservatism.

The equipment needed for pudendal block in the home takes little space in the obstetrical bag. It can conveniently be performed with the following equipment:

Ten cm. No. 20 needle.
Sterile gloves.
Four sterile towels and clips.
Antiseptic.
Twenty c.c. syringe.
Procaine solution (1%).
Epinephrine 1:1000.

A spinal needle may be used if no other is available. Extra sterile gloves will be needed if a finger is inserted into the rectum. Sheldon[12] recommends 1% Lysol or 1:5,000 mercuric chloride solution as a skin antiseptic for home use, though any relatively non-irritating surgical antiseptic may be used after shaving

and thorough cleansing with soap and water. Additional syringes and Luer-lok equipment are desirable but not necessary.

The importance of proper preparation of the 1% solution of procaine hydrochloride cannot be overestimated. A quick and handy method of preparing the 1% solution is to mix a 5 c.c. ampoule of sterile 20% procaine hydrochloride with 95 c.c. sterile physiological saline. Some physicians boil the saline in the home before use; the procaine should not be boiled. If solutions are made from procaine tablets, it should be noted whether the manufacturer's directions call for distilled water, physiological saline, or saline other than the usual 0.9%.

The combination pudendal block and infiltration technique of Urnes and Timerman[7] is as follows: "With the patient in an exaggerated lithotomy position, intradermal wheals are made bi-laterally half way between the rectum and the tuberosity of the ischium. One percent procaine hydrochloride with 2 minims (0.12 c.c.) of epinephrine (1:1000) per ounce is used. The index finger of the left hand inserted into the rectum palpates the left ischial spine. A 10 cm. needle is passed horizontally through the cutaneous wheal directly to the spine and then allowed to slip just under and beyond it. Because of the direction of the needle and the guiding hand in the rectum, there is no danger of piercing the rectum. From 10 to 15 c.c. of solution is deposited at this point, blocking the pudic (pudendal) nerve as it passes dorsal to the spine of the ischium just before entering Alcock's canal. The needle is then withdrawn until it lies just beneath the skin. The direction is changed laterally toward the tuberosity of the ischium, and the needle inserted until the point strikes bone. Five c.c. is injected while the needle is gradually being withdrawn. This anesthetises the large perineal branch of the posterior cutaneous femoris. Again the needle is withdrawn until it lies just under the skin, and its direction is changed vertically upwards. While it is advancing, 5 c.c. is deposited in the subcutaneous tissue of the labium minus, blocking the perineal fibres of the ilioinguinal nerve. The procedure is repeated on the opposite side, the operator using the same finger in the rectum, or changing to the index finger of the right hand. The vaginal mucosa and the skin of the perineal area as high as the clitoris become anesthetised within 5 minutes."

In hospital practice the guiding finger may be introduced into the vagina rather than rectum. When this is done, a vaginal antiseptic should be used. When the rectal technique is used, I prefer to complete the superficial infiltration before entering the rectum. A total of 50 to 70 c.c. of procaine solution is used. Slight constant rotation or withdrawal of the needle will prevent appreciable intravenous injection of procaine.

A few c.c. of procaine may well be injected into the episiotomy site to insure prolonged anesthesia. This additional infiltration will permit later repair without further infiltration and is much more easily done before the episiotomy than afterwards.

Summary

1. Pudendal block is a simple, safe, and moderately satisfactory form of obstetrical anesthesia.

2. Pudendal block is admirably adapted for use in home obstetrics and selected hospital cases.

3. The technique of Urnes and Timerman of the Chicago Maternity Center is given in detail.

Bibliography

1. Buxbaum, H., "Local Anesthesia," *Am. J. Obs. and Gyn.*, 48:90-93: July, 1944.
2. DeLee, J. B., and Greenhill, J. P., "The Principles and Practice of Obstetrics," W. B. Saunders Company, 1943.
3. "Williams Obstetrics," 8th Ed., D. Appleton-Century, 1941.
4. "Year Book of Obstetrics and Gynecology," The Year Book Publishers, 1943.
5. a. Buxbaum, H., "Obstetrics in the Home," *S. Clin. N. America*, 23:45-58: Feb., 1943.
   b. Palmerton, E. S., "Obstetrics in the Home," *Minnesota Med.*, 26:176-179: Feb., 1943.
6. Garrison, J. E., "Delivering Babies in the Home," *J. M. A. Alabama*, 12:228-231: Feb, 1943.
7. Urnes, M. P., and Timerman, H. J., "Breech Delivery: A Comparative Study of Local and General Anesthesia," *J. A. M. A.*, 109:1616-1618: Nov. 13, 1937.
8. Abrams, S. F., "Block of Pudendal Nerve in Obstetrics," *J. Missouri M. A.*, 35:81-83: March, 1938.
9. Philpott, N. W., "Local Anesthesia in Obstetrics," *Canad. M. A. J.*, 45:539-542: Dec., 1941.
10. Rosenfelt, S. H., "Combination of Local and General Anesthesia in Obstetrics," *Am. J. Surg.*, 58: 207-210: Nov., 1942.

Continued on page 83

*The Problem of Acute Gastro-Intestinal Hemorrhage**

Edward H. Risley, M. D., Waterville, Maine

This paper is a discussion of a condition which, fortunately is comparatively rare, but, when it does occur, demands the very best skill and thought that can be mustered.

In the large majority of instances it is the general practitioner who first sees these acute cases, and on his good judgment largely depends the successful outcome of the case.

These acutely bleeding ulcers are the desperate cases—the acutest kind of emergencies and demand surgical consultation and close cooperation between the Internist and the Surgeon throughout the illness.

The fact that there still exists a very considerable disparity in the opinion regarding the efficiency of medical versus surgical treatment makes this coöperation all the more important.

This paper deals primarily with massive hemorrhage from gastric and duodenal ulcer. But in order to clarify the situation, passing mention must be made of those lesions which cause small and large intestine hemorrhage.

In a considerable accumulation of literature it has been brought out fairly clearly that when one is confronted with massive hemorrhage from the intestinal tract, if the history of the case does NOT strongly suggest intestinal neoplasm—(Varying from benign polyps to actual carcinoma) and vomiting of blood is present, the hemorrhage is in all probability either gastric or duodenal in origin.

In considering purely intestinal hemorrhage one must take into account both age and the various segments of the intestinal tract.

In infants, children, and those under 40 years, one must consider intussception, Meckel's diverticulum, polyps and ulcers of the small intestine. And in the older age groups, Meckel's diverticulum, ulcerative colitis, diverticulitis, polyposis and malignancy.

Except in a comparatively few instances a searching history and a thorough physical examination will point pretty definitely to that part of the intestinal tract involved.

It is also known that, in the great majority of cases of hemorrhage from the intestinal tract, the amount of blood loss is rarely as great as that from peptic ulceration.

When one is confronted with a case of massive hemorrhage, two things must be considered at once.

(1) The availability of a good hospital, and (2) a surgeon competent to handle the case if the advisability of surgical treatment is agreed upon.

It is impossible to handle these critical cases successfully in the home. The danger of removal is outweighed by the greater facilities for adequate treatment in a well-equipped hospital.

Diagnosis

The determination of the exact site of the bleeding lesion is often extremely difficult — or impossible.

A history of previous indigestion is totally lacking in many cases; the exanguinating hemorrhage being the first symptom the patient has ever had.

In arriving at an accurate diagnosis the following conditions must be considered.

1. Rupture of esophageal varices — often confirmed by finding an enlarged liver.

2. Hemorrhage from gastric or duodenal ulcer.

3. Severe gastritis, polyposis or gastric malignancy. These three lesions are always accompanied by hematameses as well as tarry stools.

4. As we proceed down the intestinal tract vomiting of blood becomes rarer or entirely absent — unless the hemorrhage in the upper small intestine is so massive as to cause reversed peristalsis and expulsion of the blood through the stomach (rare).

One can safely say that if a patient has massive intestinal hemorrhage without nausea or vomiting the chances are that the lesion is in the lower small or the large intestine, and, conversely, if nausea and vomiting of blood occur, the chances are that the lesion is gastric or duodenal.

---

* Presented at the 91st Annual Session of the Maine Medical Association at Rockland, Maine, June 27, 1944.

Pathology

The site of the ulceration is largely responsible for the amount of hemorrhage. It is bleeding from the ulceration of a posterior duodenal ulcer that is most likely to result fatally.

In this situation, a penetrating ulcer with a necrotizing base in the head of the pancreas is usually found and a branch of the superi or pancreato-duodenal artery is frequently eroded, and, unless this can be quickly tied off, the resulting hemorrhage is bound to be fatal.

Symptomotology

As previously stated, there may be no premonitory symptoms before the sudden massive hemorrhage — or one may get a history of indigestion over a varying period of time.

A searching history should always be attempted in order to establish as accurate a diagnosis as possible.

The generally accepted belief that perforating ulcers do not cause severe hemorrhage is not true.

Treatment

The extremely contraversial subject of treatment is the main object of discussion in this paper.

Since about 1935, surgical as opposed to the old ice bag, starvation, morphia, conservative treatment, has had constantly increasing numbers of adherents, based largely on the high mortalities reported with conservative treatment, and the failure of this form of treatment to demonstrate any improvement in results over a considerable period of trial.

It is recognized, of course, that the patient with a massive hemorrhage is the worst possible surgical risk and that his surgery must be done at the lowest point in his critical stage, and, also without the benefit of any effective type of pre-operative preparation, with the possible exception of transfusion.

Therefore the decision for or against surgery is a most difficult one.

And the present weight of mortality statistics is not as yet convincing enough, one way or the other, to help in making a clean-cut decision for or against one form of treatment or the other.

Allen and Benedict believe that 50% of patients of 45 or over, who have bleeding ulcers, will have massive hemorrhage, and that 35% of these will die if treated expectantly.

The mortality figures for surgical intervention vary greatly. However, it is pretty definitely proven that the principal factor which influences the result is the time interval between the onset of hemorrhage and the operation.

Finsterer reports a comparable series of cases which illustrate this point dramatically.

In 35 immediate resections for massive hemorrhage there was but one death — a mortality of 2.8%.

While with 42 late—(48 hours or longer) resections, there were 13 deaths or a 31% mortality.

Finsterer, therefore, believes that a decision should be made at once, whether conservative or surgical treatment is to be employed, and, if surgery is decided upon, it should be carried out at once, with the expectation of a favorable result, if done within the first 48 hours.

One might well ask, "Are there any reliable aids to an accurate diagnosis and any help in making the difficult decision?"

I think there are a few established facts, which, if carefully weighed, will be of some help.

1. The incidence and mortality from hemorrhage from ulcer is greater for men than for women, and rises with age and arterio-sclerosis and hypertension.

2. Hemorrhage from duodenal ulcer causes a higher mortality than that from gastric ulcer.

3. Hemorrhage from chronic ulcer is more liable to be fatal than from acute ulcer.

4. Mortality rises rapidly with a second or third hemorrhage following any unrelieved bleeding.

5. According to Allen and Benedict, the eventual survivors pick up rapidly after the first prostration.

Allen thinks that the age of the patient has more bearing on the cessation of bleeding than almost any other factor.

6. The mortality increases rapidly after 50 and all patients between 40 and 50 should be placed in the dangerous group.

These are salient facts and if studied carefully may be of considerable help.

General Management

Before trying to draw too definite conclusions for or against surgery, let us consider for the moment the problem of the general management of this critical type of case. This should follow a pretty definite routine, as follows:

1. Hospitalization.
2. Treatment of shock — avoiding stimulants and intravenous infusions.
3. Hourly pulse and blood pressure readings — special nursing.
4. Immediate typing of donors.
5. Introduction of Levine tube into the stomach for lavage with warm saline and aspiration of blood until the stomach is free from old blood.

This prevents nausea and vomiting and is of definite diagnostic value according to Bohrer of the Knickerbocker clinic.

He states that if after the stomach is empty, bright red blood continues to return through the tube, this can be taken as evidence that bleeding is still active, probably arterial, and indicates immediate operative relief.

Soper reports four cases in which the bleeding artery was located and tied off and all patients made normal recoveries.

According to this report we have here one very definite indication for early surgical intervention.

The much mooted question of the value or danger of transfusion is well discussed by Hinton in his paper on massive hemorrhage; the sub-title of which is, "The Transfusion Test for Determining the Necessity for Operation." (*Ann. Surg.,* Sept., 1939.)

He believes that transfusion may prove a valuable method by which a more definite decision can be made for or against surgical treatment. We will take a suppositional case.

A patient with a blood pressure around 80/60, a red cell count of a little over 2 million, and a hemoglobin of about 30%, obviously needs immediate supportive treatment.

If, after 500 cc. of blood is given, there is no improvement in the blood picture, one may assume that bleeding is still active, and probably a large vessel is eroded. If then a further 500 cc. is given and still no improvement takes place it will be evident that a fatality will result unless surgery is immediately resorted to and the bleeding stopped.

In operating on these desperate cases, a continuous transfusion of 1000 cc. is started at the onset of the operation.

Hinton believes that sub-total gastrectomy is the operation of choice. He thinks it is not safe to excise an anterior ulcer alone and assume that this will control all bleeding, for about 15% of cases have a posterior ulcer also, which continues to bleed.

It is definitely recognized that gastro-jejunostomy is of no avail in stopping ulcer hemorrhage. Hinton also makes the dogmatic statement that a trans-duodenal operation with suture or cauterization of the ulcer is an unsurgical procedure. In rare cases only is it successful, but there is always the danger of increasing bleeding by cauterizing the pancreatico-duodenal artery.

As a direct contrast to this viewpoint, Pfeiffer states that the object of operation in massive hemorrhage, is not the cure of the ulcer but the immediate checking of hemorrhage, and advocates gastrostomy, which he claims gives access to most bleeding vessels, which can be either tied or cauterized—and—then a gastro-duodenostomy performed, which in many cases is curative, and does not prevent the performance of sub-total gastrectomy later should a cure not result.

The answer to these diametrically opposite views lies in the individual experience of the operating surgeon and probably no hard and fast rule should be followed.

Recurrent bleeding under medical treatment indicates unfavorable progress in the ulcer, and in such cases, sub-total gastrectomy should be done. This, however, is not an emergency procedure.

Feeding

This is also a very contraversial subject, but the tendency at the present time is toward feeding as opposed to the old morphia, ice cap, starvation regime.

Carlson argues that an empty stomach is one in which active peristalsis and hyper-secretion take place.

After hemorrhage the stomach is empty—of food—or filled with blood—usually clotted. This blood with its high protein content acts as a powerful stimulus for the production of gas-

tric juice. A stomach partly filled with food, which combines rapidly with gastric juice, is preferable to an actively contracting stomach full of secretions which are likely to digest the clots plugging the bleeding vessels.

Feedings are therefore recommended and carried out on the following lines:

Four-ounce gelatin mixture every 1½ hours —for 3 days. (Consists of 30 gms. gelatin, 90 gms. lactose in 1000 cc. water and flavored with orange juice.)

For the second 3 days this is increased with cereal gruel and milk, then a coddled egg, custards, jello, and gradually working up to a liberal ulcer diet.

We have had but small experience with this method but can state that the last 3 bleeding ulcer cases we have seen have not been starved and we are inclined to believe that Carlson's method is a sane procedure.

Summary

Massive hemorrhage from gastric or duodenal ulcer is one of the most acute emergencies and requires close coöperation between surgeon and internist.

Hospitalization is absolutely essential for successful treatment.

The decision for or against surgery is an extremely difficult one, but should be made within the first 24 to 48 hours.

A trial of repeated transfusions is justifiable and may be the indicator for or against surgery.

Repeated bleedings probably demand surgery and probably resection rather than less radical methods.

The use of the Levine tube is also of value and may also be an early indicator for operation.

In closing, I quote a recent editorial by Balfour of the Mayo Clinic in which he states:

"The present status of the management of acute hemorrhage from the stomach or duodenum may be summarized by saying that until there is some more definite means than are now available for recognizing the small percentage of patients who will succumb to hemorrhage—any attempt to employ surgical methods in other than those cases in which severe recurrence of bleeding takes place while the patient is under treatment for hemorrhage, will result in unnecessary deaths, and in sufficient number so that the mortality in hemorrhagic ulcer will be higher under surgical treatment than it will be under medical management."

Bibliography

Allen, A. W., and Benedict, E. R., *Annals of Surgery,* 736-749, Oct., 1933.

Balfour, D. C., *Surg., Gynec. and Obst.,* 551-553, Oct., 1937.

LaDue, J. S., *J. A. M. A.,* 113, No. 5, July 29, 1939.

Finsterer, H., *Surg., Gynae. and Obst.,* 291-298, Sept. 1939.

Bohrer, J. V., *Ann. Surg.,* V. 114, No. 4, Oct., 1941.

Hinton, J. W., *Ann. Surg.,* V. 110, No. 3, Sept., 1939.

Pfeiffer, D. B., *J. A. M. A.,* V. 111, No. 24, Dec. 10, 1938.

Welch, C. S., and Yunich, A. M., *Surg., Gynae. and Obst.,* March, 1940.

---

*Pudendal Block Anesthesia in Home Obstetrics—**Continued from page 79*

11. Bland, P. B., and Montgomery, T. L., "Practical Obstetrics," F. A. Davis Co., 1939.

12. Sheldon, C. P., "Pelvic Delivery Under Local Infiltration Anesthesia," *New England J. Med.,* 224: 404-408: March 6, 1941.

13. Greenhill, J. P., "Infiltration Versus Spinal Anesthesia in Obstetrics and Gynecology," *J. A. M. A.,* 102:28-32: Jan. 6, 1934.

14. Smith, D. J. N., "The Suture of the Perineum Using Local Anesthesia," *J. Obs. and Gynaec. of the Brit. Emp.,* 48:610-618: Oct., 1941.

15. Bunim, L. A., "The Effect of Local Anesthesia by Means of Pudendal Nerve Block with Novocain on Cervical Dystocia Occurring Late in the First Stage of Labor," *Am. J. of Obs. and Gyn.,* 45:805-811: May, 1943.

Hospitals in general are reluctant to adopt the modern methods of tuberculosis control because of the expense involved. A similar stand was taken by industry not many years ago in reference to industrial hygiene and medicine. Experience, however, has convinced industry, large and small, as Dr. Victor G. Heiser puts it that, "In war or in peace, no plant is too small to profit from a health program." Maxim Pollak, M. D., *Hospitals,* Sept., 1944.

Editorials

1945 Annual Session Cancelled

The Council of the Maine Medical Association at a meeting held Sunday, April 22nd, at Augusta, Maine, voted to cancel the 1945 annual session, scheduled for June 24, 25, 26, at the Poland Spring House, Poland, Maine, in compliance with a ruling of the Office of Defense Transportation that all meetings with an expected attendance of over fifty be cancelled.

It was voted to hold a meeting of the House of Delegates on Sunday, June 24, 1945, at the Augusta House, Augusta, and your Secretary was instructed to contact each County Secretary and request that they ascertain from their membership their feeling relative to new officers being elected for 1945-46, or the present officers being retained.

Each County Society should carefully instruct its delegates relative to any matters that they feel should come before the House of Delegates, and each Delegate should be present at this meeting in order that the business of the Association may be carried on in accordance with the Constitution and By-Laws.

Any delegate who cannot attend should immediately notify his alternate in order that each County Society may have present at this meeting the entitled number of representatives.

Red Cross Releases Gamma Globulin for Measles Prevention at No Cost

"Immune serum globulin (gamma globulin) [one of the fractions or components of blood plasma which contains all of the so-called antibodies in the blood] for the prophylaxis, modification and treatment of measles," *The Journal of the American Medical Association* for March 10 reports, "is now available for the civilian population through an appropriation by the American Red Cross as announced by Mr. Basil O'Connor, chairman of the Central Committee of the American Red Cross. This action is in keeping with the policy of the American Red Cross to return to the American people as far as practicable, any useful blood derivatives accumulated in excess of military needs as a result of its blood donor program.

"The serum globulin will be supplied without charge to state and territorial health departments or local health departments where biologic products are not supplied by the state, provided the globulin will be distributed without charge to physicians, hospitals and clinics, and provided it will be administered in accordance with established standards and without any charge to the patient for the globulin.

"As announced in the July 1, 1944, issue of *The Journal*, health departments assumed the costs of processing and distributing immune serum globulin. Under the new plan the entire cost of processing and distributing the product is now borne by the American Red Cross.

"The crude serum globulin fraction thus made available is derived as a by-product from processing serum albumin under Navy control. It has been declared surplus and assigned by the Navy to the American Red Cross for distribution.

"Eligible health agencies are being requested to place their orders promptly with National Headquarters, American Red Cross, Washington, D. C., attention of Dr. G. Foard McGinnes, National Medical Director."

Two more reports indicating the value of penicillin appear in *The Journal of the American Medical Association* for March 10. In one, the drug was found effective in treating infantile congenital syphilis (existing at birth) and in the second, an infection of the pericardium (heart sac) was cured with penicillin after sulfadiazine had failed.

Speech-Conscious Americans

A friend of mine travelling in England before the war says he saw this sign outside a movie house, "No American voices are heard in these pictures." It is something of a commentary on our American voices that English moving picture producers in times past have discriminated against them. It is a criticism of our laziness in articulation, our lazy diction, and our harsh unpleasant tonal quality, and it is not entirely unjustified.

There is, however, a tremendous gain in speech interest all over the country which suggests that we are on the way to vigorous improvement. In the recent days, when the world paused for days to hear about the death of President Roosevelt, what an important part the radio and the human voice played.

Moreover, the telephone, the talkies, the movies, and general travel have all had their part in making America speech conscious. We are coming to hear ourselves as others hear us and we are not completely pleased with what we hear.

Today, all around us, groups of individuals from various walks of life are working on personality development through speech — for indeed there is no closer tie-up.

No doubt, much of the present day speech consciousness was due to President Roosevelt's use of the radio. Much of his success in winning friends and influencing people was due to his power to use clear, convincing, and pleasing speech.

For the every day person like you and me who are no longer children—is there anything we can do to improve in this direction?

Yes, we can listen to our own voices. Ear training is very important. When you really hear yourself you will find many changes you would like to make. Listen to the attractive voices over the radio. Compare them with your own, in tone quality. Is your voice harsh, too soft to be heard comfortably or too dead level expressions? Is is too low or too high in pitch?

Remember when speaking "my listener is important. I must make him feel comfortable and interested. Therefore, I must speak loudly enough, clearly enough and pleasantly enough to be heard without strain." When you are thinking of your listener instead of yourself you will avoid self conscious prissy speech.

Inflection lends variety and beauty to speech and reveals the personality behind it. Tight lips and a sluggish tongue may be the cause of lack of inflection. The voice is colored by the emotional life. It is, in reality, the interpreter of the emotions. It must have however, for this interpretation the mechanical aids of flexible lips and a mobile tongue.

There are, therefore, a few rules that we can use for our every day guidance.

Listen to your own voice. What does it tell you?

Listen to a voice you like to hear. How is it different from your own? Watch yourself speak before a mirror. Do you use your tongue and lips flexibly or try to talk behind them?

Do I consider my listener of more importance than myself when I am speaking and give to him unselfishly of all that I have in pleasant, interested, easily heard and easily understood speech?

Time, effort, practice and a critical ear will do the rest. American speech can be beautiful.

Adrian H. Scolten, M. D.,
Portland, Me.
Fellow of the American Speech Correction Association.

As a method of tuberculosis case-finding, the screening of large groups of apparently healthy individuals by means of chest X-rays is here to stay. It should not replace the recognized routine methods of case-finding by means of examination of individuals who have been in close association with tuberculous patients or who have symptoms referrable to the lungs. Rather, it should serve as an excellent auxiliary method for the discovery of new cases and in that way provide to health departments many additional opportunities for the promotion of their tuberculosis control programs. William Siegal, M. D., *Health News,* Nov. 13, 1944.

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Henry P. Johnson, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

100% Paid Membership for 1945

Piscataquis County Medical Society
Franklin County Medical Society
Hancock County Medical Society
Washington County Medical Society
Somerset County Medical Society
Cumberland County Medical Society
Penobscot County Medical Society
Androscoggin County Medical Association
Aroostook County Medical Society

Cumberland

The annual meeting of the Cumberland County Medical Society was held March 30, 1945, at the Maine General Hospital, Portland. The following officers were elected for the ensuing year:

President, Henry P. Johnson M. D., Portland.

Vice President, John M. Bischoffberger, M. D., Naples.

Councilor, Albert W. Moulton, M. D. Portland.

Delegates to the 1945 Maine Medical Association House of Delegates (Two Years): Drs. Kenneth E. Dore, Fryeburg; Stephen S. Brown, Portland; and Francis J. Welch, Portland.

(One Year): Drs. Oscar R. Johnson, Portland; Joseph E. Porter, Portland; and Louis L. Hills, Westbrook.

Alternates (Two Years): Drs. Isaac M. Webber, Portland; and Waldo T. Skillin, South Portland.

(One Year): Drs. Theodore C. Bramhall, Portland; and Harold V. Bickmore, Portland.

Stephen S. Brown, M. D., Director of the Maine General Hospital, was the principal speaker, and selected as his topic *"Are We Going To Have State Medicine?"* He traced the development, extent and scope of the various State and Federal agencies concerned with health problems. It was pointed out that certain medical problems at the present time are controlled and financed by various Federal and State agencies. Doctor Brown felt that if we are to defeat the Murray-Wagner-Dingell bill, the American Medical Association should act immediately. A discussion of Doctor Brown's paper was opened by R. V. N. Bliss, M. D., of Blue Hill, President of the Maine Medical Association.

There were two members who transferred their membership to the Cumberland County Medical Society: Norman Dyhrberg, M. D., of Gorham; and Robert Burns, M. D., of Windham.

A very interesting clinic was presented by the staff of the Maine General Hospital at 5.30 P. M. This was followed by dinner in the dining room.

JOSEPH E. PORTER, M. D.,
Secretary.

Hancock

A regular meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, on April 11, 1945, at 6.30 P. M.

Phillip Gray, M. D., presided over a short business meeting. Following a short general discussion the meeting was adjourned.

J. H. Crowe, M. D.,
Secretary.

Lincoln-Sagadahoc

The March meeting of the Lincoln-Sagadahoc County Medical Society was held at The Ledges, Wiscasset, Maine.

F. A. Winchenbach, M. D., of Bath, gave an interesting discourse of his experiences while in the Armed Forces in World War II.

William A. Purinton, M. D.,
Secretary.

York

The Quarterly Meeting of the York County Medical Society was held Wednesday, April 11, 1945, at The New Saco House, Saco, Maine.

Dinner at 1.00 P. M. was followed by the meeting at 2.00 o'clock.

Robert Rix, M. D., of Manchester, New Hampshire, spoke on *Modern Aspects of Orthopedic Diagnosis and Surgery.*

Mr. W. Eldridge Smith, of the Commercial Casualty Company, gave a talk on Group Health Insurance.

The October meeting will be in charge of Drs. Waldron L. Morse and Marion Moulton, and will be held at the Henrietta Goodall Hospital, Sanford, Maine.

C. W. Kinghorn, M. D.,
Secretary.

New Members

Cumberland

Norman Dyhrberg, M. D., Gorham, Maine.
Robert Burns, M. D., Windham, Maine.

Notices

Cumberland County Medical Society

Cumberland County Medical Society, Joseph E. Porter, M. D., 22 Arsenal Street, Portland, Maine, Secretary.

Friday, May 11, 1945, Portland, Maine.

5.00 P. M. Clinic at the Maine General Hospital.

6.30 P. M. Dinner at the Lafayette Hotel.

8.00 P. M. Guest Speaker: Dr. I. DeForest Huddleson, University of Michigan. Subject: *Brucellosis.*

Members of other County Societies are cordially invited to attend this meeting.

New England Pathological Society

The annual meeting of the New England Pathological Society will be held at the Maine General Hospital, Portland, Maine, Thursday, May 19, 1945, at 2.00 P. M.

State of Maine

Board of Registration of Medicine

Adam P. Leighton, M. D., Portland, Secretary.

List of Physicians Licensed by this Board — March 14, 1945.

Through Examination

Frank Currier Ferguson, Jr., Maine General Hospital, Portland, Maine.

Charles Robert Glassmire, M. D., Maine General Hospital, Portland, Maine.

John Field Hubbard, M. D., 121 De Kalb Ave., Brooklyn, N. Y.

Sinet Maurice Simon, M. D., Medical Facilities, 3384 S. W., New Cumberland, Pa.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Acting Director, *Joseph E. Porter, M. D.*

Waterville: *Sisters Hospital*
1st & 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd & 4th Thursdays, 10.00 A. M.
Director, *A. H. McQuillan, M. D.*

Maine General Hospital Medical Grand Rounds

All interested physicians are invited to attend *Medical Grand Rounds* at the *Maine General Hospital* which are now held at *5.15* each *Thursday afternoon* in the *X-ray Department.*

LET'S GET THE ADMIRAL HIS HORSE!

Official U. S. Navy Photo

Admiral Halsey has his eye on a fine white horse called Shirayuki.

Some time ago, at a press conference, he expressed the hope that one day soon he could ride it.

The chap *now* in Shirayuki's saddle is Japan's Emperor—Hirohito.

He is the ruler of as arrogant, treacherous, and vicious a bunch of would-be despots as this earth has ever seen.

The kind of arrogance shown by Tojo—who was going to dictate peace from the White House . . . remember?

Well, it's high time we finished this whole business. High time we got the Emperor off his high horse, and gave Admiral Halsey his ride.

The best way for us at home to have a hand in this clean-up is to support the 7th War Loan.

It's the biggest loan yet. It's two loans in one. Last year, by this time, you had been asked twice to buy extra bonds.

Your personal quota is big—bigger than ever before. So big you may feel you can't afford it.

But we *can* afford it—if American sons, brothers, husbands can cheerfully afford to die.

ALL OUT FOR THE MIGHTY 7th WAR LOAN

MAINE MEDICAL ASSOCIATION

This is an official U.S. Treasury advertisement—prepared under auspices of Treasury Department and War Advertising Council

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Rockland, Rumford, Sanford, Waterville, Wilton, Millinocket, Old Town, Portland, Presque Isle, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.

Doctors Look Ahead

"Doctors Look Ahead," a series of dramatized episodes devoted to medical progress and research at home and abroad, is presented by the American Medical Association and the National Broadcasting Company each Saturday at 4.00 P. M., Eastern War Time, unless otherwise announced in local newspapers.

Topics in the series, which began January 6 and will continue through June 30, will be announced weekly in *The Journal of the American Medical Association.*

The broadcast is under the supervision of the American Medical Association's Bureau of Health Education, whose director, Dr. W. W. Bauer, will summarize each program except when other speakers are announced.

Book Reviews

"Manual of Military Neuropsychiatry"

Edited by: Harry C. Solomon, M. D., Professor of Psychiatry, Harvard Medical School, Medical Director at the Boston Psychopathic Hospital.
Paul I. Yakovlev, M. D., Clinical Director, Walter E. Fernald State School, Instructor in Neurology at the Harvard Medical School.

Published by W. B. Saunders Company, Philadelphia and London, 1944. 764 Pages. Price, $6.00.

This manual is a condensed reference text on clinical neurology and psychiatry. It is written especially for physicians in military service. The material in this book is contributed by a staff of forty-five specialists on the subjects which are described. The book is divided into six parts; the first deals with neuropsychiatric experiences of First World War and the role and general organization of neuropsychiatry in the Army during the current war. Part two deals with neuro-

psychiatric screenings at the induction station. Part three outlines the administration and disposition in which we find information relative to the organization of the medical department and duties of the medical officer and neuropsychiatrists. Part four deals with clinical entities. Part five deals with prophylaxis and therapy. Part six deals with special topics.

This book is of much value to those interested in the problems of neuropsychiatric and neurological conditions in the military service.

"Doctors At War"

Edited by: Morris Fishbein, M. D., Editor of the Journal of the American Medical Association and of Hygeia, The Health Magazine; Chief Editor of War Medicine; Chairman of the Committee on Information of the Division of Medical Sciences of the National Research Council.

Illustrated with Photographs and Charts.

Published by E. P. Dutton & Co., Inc., New York, 1945. Price, $5.00.

This book covers practically every phase of medical warfare, and is a record of American doctors' accomplishments on every fighting front, on the land, every sea and in the air. It is written for the layman as well as the doctor by sixteen leading authorities responsible for organizing our medical warfare. In Chapter I it states that the "annual death rate per 1,000 for all disease in the Army, excluding surgical conditions for World War I was 15.6%, and for World War II 0.6%." "Our surgeons have established a record in the care of the wounded which is unparalleled in the history of warfare and is little short of miraculous. As of 1944, the over-all mortality rate among the wounded in the Army was approximately 3 per cent, which means that we saved 97 of every 100 soldiers wounded in battle, contrasted with a figure of more than 8 per cent in the last war."

"Dietotherapy"

Clinical Application of Modern Nutrition

Edited by: Michael G. Wohl, M. D., Associate Professor of Medicine, Temple University School of Medicine; Chairman, Advisory Committee on Nutrition, Philadelphia Department of Public Health.

With a foreword by Russell M. Wilder, M. D., Ph. D., Professor of Medicine and Chief of the Department of Medicine, Mayo Foundation.

1,029 Pages. Illustrated.

Published by W. B. Saunders Company, Philadelphia and London, 1945. Price, $10.00.

This book was written by 58 American authorities under the editorship of Michael G. Wohl, M. D., to provide the general practitioner of medicine with a source of guidance and workable advice on many nutritional problems. The dietary treatment is given in complete detail. It is divided into three parts. Part One is entitled "Normal Nutrition;" Part Two, "Nutrition in Periods of Physiologic Stress;" and Part Three, "Nutrition in Disease;" with chapters on nutrition in digestive diseases, dietary treatment of diabetes mellitus, nephritis, cardiovascular disease, rheumatism, arthritis and gout, pernicious anemia and nutrition in the care of surgical patients, pre-operative and post-operative, etc.

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, June, 1945 No. 6

*Acute Abdominal Emergencies**

Arthur H. McQuillan, M. D., Waterville, Maine

The acute abdomen is a rather loose term applied to that group of acute abdominal lesions demanding immediate surgical interference, even though the causative lesion is not always diagnosed preoperatively. Because of the difficulties and complications of diagnosis, careful consideration and localization of the pain and associated symptoms is more important here than in any other region of the body. These lesions demanding that interference in the order of their usual frequency in civilian practice are as follows:

1. Acute appendicitis.
2. Ruptured peptic ulcer.
3. Peritonitis (secondary to many primary causes).
4. Intestinal obstruction, whether from hernia, adhesions, volvulus, intussusception, or malignancy.
5. Ectopic pregnancy.
6. Ovarian cyst with twisted pedicle.
7. Acute hemorrhage pancreatitis.
8. Acute gall bladder (with perforation).
9. Mesenteric thrombosis.
10. Diverticulitis.
11. Ruptured viscus, traumatic.
12. Penetrating abdominal wounds.

In addition to these we must also consider renal and biliary colic, acute salpingitis, pneumonia, coronary thrombosis, tabetic crises, and diabetic coma, as they often simulate the acute abdomen.

The differential diagnosis of these lesions will be discussed symptomatically and collectively together and not as different distinct disease entities. First we will take up History.

Previous history often plays a most important role, as in the history of previous attacks of appendicitis. Ulcer patients often relate the history of hunger pain with food and alkali relief occurring in cycles. Bowel obstruction often gives the history of hernia or previous abdominal operation. Patients with ectopic pregnancy may have had long periods of sterility, Neisserian or puerperal infection. Nearly all of these patients have had from one to three months of disturbed menstruation or the typical spotting after a month or two of amenorrhea, at times associated with morning sickness. Most cases of ovarian cyst have had

* Read at a meeting of the Penobscot County Medical Association, Bangor, Maine, May, 1944, at Station Hospital, Presque Isle, Maine, 1944, and at the Thayer Hospital Staff meeting, Waterville, January, 1945.

prolonged periods of disturbed, abnormal, and painful menstruation, attacks of pain in one or the other of the lower quadrants due to temporary torsion, while some individuals know of the cyst's presence. Most patients with an acute gall bladder and hemorrhagic pancreatitis remember a prolonged series of biliary symptoms. A recent attack of auricular fibrillation or blood stream infection, the presence of endocarditis or arteriosclerosis are suggestive of thrombosis, mesenteric or coronary. Renal colic patients have frequently previously passed a stone or gravel. A venereal history may suggest tabetic crises, and, in this day and age, very few patients go into a diabetic coma without knowing that they have diabetes. So a complete history from the patient or his family, or both, is very often helpful even in acute abdominal emergencies.

The onset of the pain may be sudden or it may occupy only a few hours in appendicitis, in peritonitis, bowel obstruction, diverticulitis, salpingitis, and pneumonia, while in ectopic gestation the pain, although sudden, may have a prolonged history of onset due to a slow leak. Perforation of the gall bladder is usually sudden in onset, but is nearly always preceded by at least one attack of gall bladder colic. The same is true of hemorrhagic pancreatitis. Perforated peptic ulcer, mesenteric and coronary thromboses, ovarian cyst with twisted pedicle, biliary and renal colic are notoriously sudden in onset, although biliary colic is often only a nocturnal affair.

Pain—The pain of appendicitis is quite diagnostic, only when it comes in the classical manner of being at first generalized and later concentrating and localizing in the right lower quadrant and leaving the remainder of the abdomen free until perforation and peritonitis develop. And then there is the typical history of varying periods of relief from symptoms. The pain of right-sided ureteral colic is usually over the cecum, or the ilioinguinal or iliohypogastric nerves, colicy in nature and often associated with frequency of urination, dysuria, and hematuria. The pain referred from pneumonia is usually moderate, constant, and often associated with pain in the chest. Perforated peptic ulcer may cause pain in the right lower quadrant, but usually the first discomfort is in the epigastrium and later extends to the entire right abdomen. However, the usual pain of ruptured ulcer is prostrating and epigastric, often causing the patient to fall to the floor or faint. It often radiates to the back and right hypochondrium. It extends to involve more areas as time passes, and is usually increased by vomiting, by pressure, by movement, by jarring, and requires large doses of morphine for relief, quite like the pain of coronary thrombosis.

In generalized peritonitis the pain is diffuse, constant, moderately severe, does not radiate, and is relieved only by sedatives. The pain of obstructed bowel is more often a generalized abdominal cramp with complete relief between paroxysms. Often there is moderate discomfort at the site of obstruction, as in hernia. The pain of a tabetic crisis is more like that of duodenal or very high jejunal obstruction, being gripping, not radiating, and being accompanied by vomiting from the beginning.

The pain of ectopic pregnancy is extreme and prostrating in its sudden severity. It originates and remains in one of the lower quadrants, although it extends as the exuding blood invades new areas of the peritoneum. It is increased by movement and pressure and occasionally subsides in a few cases where the hemorrhage is spontaneously arrested.

The complete twisting of the pedicle to an ovarian cyst is usually quite sudden, acute, and often severe enough to cause shock. It arises in one of the lower quadrants, does not radiate or move as a rule, and is usually constant and progressive. If the torsion is only partial, the symptoms are less and proportional to the amount of vascular obstruction present.

Acute hemorrhagic pancreatitis is ushered in with acute, severe, epigastric pain, which persists and which is like perforated ulcer, and is only relieved by large doses of morphine; food, vomiting, pressure, and change of position offering no relief.

Mesenteric thrombosis causes a sudden, severe, diffuse abdominal pain that does not radiate. It is not relieved by vomiting, by movement, or by pressure, and is aggravated by food and by laxative.

Diverticulitis causes pain somewhat similar to that of appendicitis, but is usually in the left lower quadrant or pelvis, as diverticuli of the sigmoid are most common.

So much for pain. We will now consider the

symptom of vomiting. Vomiting usually always occurs some time in the course of every acute abdominal emergency, but it may be absent in any except ileus. In appendicitis, diverticulitis, ectopic gestation, and twisted ovarian cyst it is usually early and then ceases. The vomitus consists of gastric contents, then yellow to green bile, and will not be bloody unless there is severe straining. With ileus from any cause, it is early, persistent, and often projectile, the higher the obstruction, the more frequent and less fecal. In mesenteric thrombosis it is often bloody. The vomitus of perforated ulcer is seldom bloody, and if so, is usually of coffee-ground appearance.

Bowel movements—With appendicitis, diverticulitis, ruptured ulcer or gall bladder, pancreatitis, or peritonitis, constipation is the rule, enemas are usually feebly expelled and often obtain poor fecal results. Bowel obstruction will have no fecal matter or gas after the bowel below the obstruction is emptied. In mesenteric thrombosis, the stools are often bloody, as in some cases of malignant obstruction, while with intussusception bloody mucous only may be quite abundant and frequent.

Shock occurs most frequently in the perforative lesions, as ulcer, gall bladder, ectopic pregnancy. It also occurs in pancreatitis, mesenteric thrombosis, and twisted ovarian pedicle. The more rapid the onset, the more profound is the shock. Its presence is indicated by weakness, fainting, pallor, sweating, coldness of skin, subnormal temperature, low blood pressure, and increased, weak pulse. In from one-half to two hours the patient usually reacts from shock. Continued shock or recurrent shock usually means additional insult, as more leakage in a perforation or more hemorrhage in a continually bleeding ectopic pregnancy. Coronary thrombosis often imitates shock, but the condition is one of actual progressive cardiac failure, rather than the reflex vascular instability which is known as shock.

Temperature and pulse — After the patient has reacted from shock the temperature is usually elevated, an exception being bowel obstruction, and in renal or biliary colic and tabetic crises the temperature is usually not elevated. In pneumonia it is usually high. High fever early in an attack usually militates against the diagnosis of an acute abdomen. The rising pulse rate seen in acute abdomens is usually increased out of proportion to the rise in temperature.

Tenderness is present in all inflammatory lesions from a slight to a moderate degree. It is marked in pancreatitis and is marked and exquisite in perforated ulcer, gall bladder, and ectopic pregnancy. In obstruction cases very little tenderness is present early unless there is an external hernia, in which case it is over the protrusion. The location of the tenderness usually is most marked at the area of the offending lesion.

Rigidity corresponds very closely in occurrence, severity, and location with tenderness, as it is the second step in the protective mechanism of which tenderness is the first, a notable exception being the board-like rigidity in perforated ulcer, while in pancreatitis it is usually slight to absent.

Peristalsis should be determined before palpation sets up abnormal activity, and remember that sedation inhibits, while laxatives and enemas stimulate, peristalsis, and their use before physical examination must be evaluated. It is nearly always decreased in inflammatory lesions, inhibited in perforated lesions, and augmented in obstructive lesions.

Percussion is of value in determining the presence of fluid or free gas in the peritoneal cavity, and in differentiating a distended abdomen due to fluid from tympanites or obesity. Increased dullness in the flanks or other dependent portions of the abdomen or localized abnormal areas of dullness indicate fluid. If it is not retained by adhesions it will shift on change of position. Obliteration of liver dullness in a distended abdomen usually means perforation of an ulcer which causes pneumoperitoneum, while if the area of liver dullness remains in a distended abdomen it is usually due to tympanitis. This occurs early in mesenteric thrombosis and later in other obstructive lesions. A distended abdomen and a uniform dull or flat note, except for a cap of resonance at the tip of the dome, indicates ascites, pus, or blood.

Blood count—There is usually an increased leukocyte count with a relative increase of polymorphonuclears in all inflammatory and perforative lesions, being much greater in those associated with peritonitis or hemorrhage, while

there is very little change in obstruction. Hemorrhage will cause a fall in the red blood cells and hemoglobin and is often a very valuable diagnostic aid, as well as a prognostic guide.

Blood chemistry is oftentimes an all important factor in the study of the acute abdomen. It is invaluable in diabetic coma where we find the highest elevation, and in one dramatic condition, usually ushered in by an attack of weakness and a chill a few hours after a meal, the blood sugar level will be very low. This is seen in benign adenomas of the islets of the pancreas. The diagnosis of acute pancreatitis is made easier if there is a blood amylase determination made. The blood amylase in this condition is elevated for from forty-eight to seventy-two hours after the onset of the attack, when it gradually returns to a normal level of from 70 to 150. There is a reduction of blood chlorides and retention of urea in intestinal obstruction. This is not usually an early finding.

X-ray studies are likewise invaluable in all cases of intestinal obstruction, particularly so when two views are made, one, if possible, with the patient in the upright position or at least with the patient turned on one side or the other, to compare with the usual recumbent position, in which flat plates are made. The use of a barium meal is not as a rule recommended in acute abdominal conditions, even in cases of doubt. It would not be tolerated by a patient who is vomiting, and would add nothing to the flat abdominal plate. The use of the barium enema may be considered and may be helpful, but even here I would try proctoscopy first.

In ruptured viscus or penetrating abdominal wounds the best advice that I know of is to offer early exploration just as soon as the patient's condition warrants it. When the diastolic blood pressure rises above 40 it may usually be presumed that the period of severest shock has passed. All penetrating abdominal wounds should be explored and exploration should be done if there is:

1. Doubt of the actual state of intra-abdominal affairs.
2. Persistent pain, tenderness, and rigidity.
3. The presence of internal hemorrhage.
4. Peritonitis.

However, to await the onset of peritonitis usually is an admission of neglect or ignorance and greatly increases the mortality.

The management of perforating abdominal wounds demands a familiarity with practically every technical procedure used in abdominal surgery. We should never venture an exploration of these patients without anticipating all the many problems which may have to be met. There is nothing more important than the personal inventory of the equipment to be used to make sure no particular piece of apparatus will be missing when it is wanted, usually in a hurry. Experience, skill, and ingenuity must be an integral part of the armamentarium of the operator who assumes the burden of this type of surgery.

I have purposely omitted for discussion such topics as preoperative preparation of the patient, technical procedures employed, including choice of incisions and post operative care with the problems of chemotherapy.

No plan for tuberculosis control in industry is complete unless education on the subject is continuous and has been made a large part of the program. There is much skepticism in some of the workers as well as in management of the value of educational measures. Yet no one is willing to deny the insurmountable difficulties which obstruct efforts to prevent disease where ignorance of the dangers and of the protective possibilities exists. The objective is to impart information which will function practically in the immediate routine of our common daily life. T. Lyle Hazlett, M. D., *Ind. Med.,* Mar., 1944.

When a nation goes to war, physical fitness of the young men of the country is a vital matter. Fortunately or unfortunately, fitness in our modern civilization, though desirable, is not so essential. Whether a man can chin himself seven times, or jump two feet, is not so important, but maintenance of good health is important. We can recollect many examples of individuals who would be rejected for military service but have been outstanding in business, the professions and the arts. These men and women have triumphed in spite of physical disabilities. Ed., *Minn. Med.,* Dec., 1944.

The Use of Prostigmine in Arrested Poliomyelitis

George Geyerhahn, M. D., 6 Albany Street, South Portland, Maine

In 1943, Kabat and Knapp[1] and also Geyerhahn[2] published on the beneficial effects of Prostigmine Bromide in Poliomyelitis in the acute stage. Recently the author has tried Prostigmine Bromide on an old case of Poliomyelitis, and since there is no known literature on the subject, it was felt worthwhile to report its effects in a chronic case. This report deals with subjective manifestations only, and there is no claim that Prostigmine has any curative effects.

This thirty-four-year-old, white female had Poliomyelitis at the age of six. From the history, the lower extremities were apparently completely paralyzed. She was given the standard treatment and support known twenty-eight years ago with exercises, massage, etc. She wore braces from the age of ten to twenty-one. The past history, family history, and review of systems was essentially negative.

Physical examination revealed a rather obese, white, middle-aged female, not appearing acutely ill. Blood pressure 120 systolic, 70 diastolic. Weight 167. Height 5′ 4″. Pulse 75. Temperature 98.4°. Respirations 20. The pupils were equal and reacted normally to light and accommodation. Ophthalmoscopic examination was not remarkable. The nose, throat, and ears revealed no abnormalities. There were no abnormal cervical glands, and the thyroid was not palpably enlarged. There was no nucheal rigidity. The breasts were well-developed. The heart was not enlarged. The rhythm was regular; the rate 75. The sounds were of good quality and there were no murmurs. The lungs were clear. The abdomen was not remarkable. The upper extremities appeared normal in every way, but there was much generalized muscular atrophy in both lower extremities which seemed more pronounced on the right than on the left.

The following is summarized from the patient's diary. Since the age of twenty-one she had not worn braces, and she felt that her condition had been stationary for several years. There was considerable difficulty with ordinary walking, and she tired easily and quickly. In June, 1944, Prostigmine was started, 15 mg., three times daily. Slowly but progressively she began to notice some changes, the first of which was that she could keep her shoes on throughout the day, that her feet felt gradually less tired and that she had less shortness of breath. On one day she was able to be up and around for fourteen hours, something which would have been impossible for her a few weeks before. Her diary reads, "Not so much effort for me to walk." She stated, however, that her legs were "nervous" at night. On June 30, she started exercises in water and also began walking in low-heeled shoes for the first time. The exercises were increased from time to time, and she found that she could gradually walk farther and tolerated her exercises better, and her feet were more comfortable.

On June 30, the medication was stopped, only to find that she became more and more limited, tired more easily, and found her exercises very difficult. On August 15, Prostigmine Bromide was again started in the same dosage, and within a few days she could swim 100 strokes. On the following day her feet felt stronger, she could walk in the water and stand alone for four minutes, and she swam 160 strokes. She was now able to go to town and walk about in the stores without being tired, and she made the statement frequently that her feet felt better. On August 31, she went camping and walked up a steep hill unassisted and could even walk with her shoes off. On September 20, the medication again was stopped, and again the old sensation of fatigue and limitation was noted. She tired quickly and was unable to walk without her high-laced shoes.

The complications of Prostigmine therapy are well-known and were experienced mildly in this patient, in that the menstrual periods were more profuse, she had occasional mild abdominal pain, and at one time the appearance of acneiform skin eruptions of the face.

Continued on page 114

1. Kabat, Herman, and Knapp, Miland E., "The use of Prostigmine in the Treatment of Poliomyelitis," *Journal of the American Medical Association,* Vol. 122, Aug. 7, 1943.
2. Geyerhahn, George, "Subjective Reaction to Prostigmine in Treatment of Poliomyelitis," *Journal of the American Medical Association,* Vol. 123, Sept. 4, 1943.

Editorial

Army Doctors in War Zones To Get Assignments in U. S.

Major General Norman T. Kirk, Surgeon General of the U. S. Army, in a message appearing in the May 19 issue of *The Journal of the American Medical Association,* says that it will be the policy of the Army Medical Department to bring back to the United States medical officers relieved from service in the theaters of operation and to assign them on their return, as long as needed, to service in their specialties in American hospitals and other installations. These men will replace physicians with similar qualifications who have not had an opportunity for foreign service.

"This information," *The Journal* says editorially, "will answer the questions of many medical officers, some of whom have written and telegraphed to the headquarters of the American Medical Association asking for a definite statement on this subject." Continuing, *The Journal's* editorial says:

"Many physicians have also written to the American Medical Association protesting against the possibility that they may be assigned on their release from service with the armed forces to the Veterans' Administration. These letters were brought before the Committee on Postwar Medical Service at its meeting in Chicago, May 12. That committee took prompt action, adopting the following statement, which was sent to the Secretary of War, Secretary of the Navy and the Committees on Military Affairs of the House of Representatives and the Senate:

" 'In November, 1944, the Army Medical Department was directed to transfer at least 300 medical corps officers to the Veterans' Administration, this number to include those officers in the zone of the interior who were formerly employed by the Veterans' Administration as civilians. Apparently about 100 men meeting the latter classification were so assigned and in addition some 200 others selected largely from among men who had been marked "limited service." Many of those thus assigned have protested and others are now protesting bitterly against these assignments on the ground that their enlistment was distinctly for military service and that assignment to the Veterans' Administration cannot be thus characterized. Many physicians who have served with distinction in both the European and the Pacific theaters of operation are now indicating by communications addressed to the headquarters of the American Medical Association the fear that they may be assigned on their return to the United States to service with the Veterans' Administration. The unwillingness to serve with the Veterans' Administration is based not only on their belief that this cannot be considered military service but also on the point of view that competent, scientific medical care is difficult under the conditions that prevail in the veterans' hospitals.

" 'The Committee on Postwar Medical Service, which includes representatives of the American Medical Association, the American College of Surgeons, the American College of Physicians, the American Hospital Association, the Federation of State Medical Licensing Boards, the Association of American Medical Colleges, the Catholic Hospital Association, the Advisory Board for Medical Specialties and many other groups, after careful consideration of the problems involved urges that the Secretary of War, the Secretary of the Navy and all others concerned with the activities of physicians voluntarily enlisted in the armed forces recognize the righteousness of the protests made by these medical officers against assignment to the Veterans' Administration. It is further urged that the needs of the Veterans' Administration for physicians be met either by voluntary enrolment of men in the armed forces at the time of their release from the service or by recruitment of medical personnel from civilian sources.'

"The American Medical Association — and this statement is made wholly in explanation of a fact that should be obvious to everyone — does not have authority to determine in any way the assignments of physicians in the armed forces. The officers of the Association would be

Continued on page 114

COUNTY SOCIETIES

Androscoggin
President, Romeo A. Beliveau, M. D., Lewiston
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Fort Fairfield

Cumberland
President, Henry P. Johnson, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Francis A. Winchenbach, M. D., Bath
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Cumberland

The Mercy Hospital, at Portland, was host to the Cumberland County Medical Society for its April meeting, which was held on the 27th of the month, and was presided over by the newly-elected President, Henry P. Johnson, M. D. The meeting was preceded by an excellent dinner served at the hospital, and those who were able to attend enjoyed a very interesting clinic presented by the staff of the hospital.

The paper of the evening was given by Adam P. Leighton, M. D., of Portland, whose topic was *Medical Intrigue, Interlopers, and Hospital Insurance Plans.* (This paper will appear in a later issue of the JOURNAL.) The paper was discussed by Drs. Stephen S. Brown, E. E. O'Donnell, and G. A. Tibbetts. The meeting was well attended.

Respectfully submitted,
JOSEPH E. PORTER, M. D.,
Secretary.

A meeting of the Cumberland County Medical Society was held on May 11, 1945, at the Lafayette Hotel. Preceding the meeting dinner was served at the hotel at 6:30 P. M. It was voted that the delegates to the Maine Medical Association meeting be instructed to elect a new set of officers for the forthcoming year.

The society was fortunate in obtaining as its principal speaker for this meeting, Dr. I. Forest Huddleston, Director of the Central Brucella Station in Michigan, and Professor of Bacteriology at the Michigan State College. Dr. Huddleston is a recognized authority on Brucellosis, and has done a major part of the original investigation on the etiology and pathogenesis of this disease. He pointed out in his paper that national figures show a slight increase in Brucellosis in the past 7 years, and that in making a diagnosis of the disease it is important to differentiate actual infection from sensitivity to the various Brucella antigens, since the latter make a rather difficult group of persons to treat, and are continually in a state of sensitization, especially if they are drinking milk or eating food which contains the proteins of Brucella, but still may not contain any viable organisms. It is interesting to know that farmers' families do not show any higher incidence of this disease than do families of other groups of individuals in larger cities. The highest incidence of the disease, which is practically 131.1 per 100,000 is found in packing house employees; it is found next most frequently in veterinarians. It was emphasized by Dr. Huddleston that the disease probably would never be eliminated from cattle; humans could be prevented from having the disease by using a certain amount of care, and if the following 4 preventive methods could be more universally instituted: (1) Pasteurization of milk; (2) Elimination of all infected animals; (3) Keeping away from or handling very carefully suspected infected material; (4) The theoretical possibility of immunization of humans. It should also be remembered that approximately 50% of the hogs in this country are infected with Brucellosis, and that this disease causes a high mortality among young pigs; furthermore, when hogs are infected they have a septicemia, and the organisms are present in all tissues.

The paper was thoroughly enjoyed by all, and great interest was shown in it. The discussion was opened

by Dr. Roscoe L. Mitchell of the State Bureau of Health, and Dr. Whitcomb, President of the state veterinarians' association. Others participating were Dr. Travis Burroughs, Director of Public Health for the City of Portland, Mr. Buzzell of the Department of Agriculture in Augusta, in charge of the Bang's disease program for the state, Dr. Ralf Martin, of the Medical Service of the Maine General Hospital, Dr. Merrill of South Paris, Dr. Webb of Brunswick, and Dr. Albert Foster of Portland.

Respectfully submitted,

Joseph E. Porter, M. D.,
Secretary.

Hancock

A regular meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, on Wednesday evening, May 9, 1945.

Phillip L. Gray, M. D., President, presided over a short business meeting.

Martyn A. Vickers, M. D., of Bangor, talked about *Some of the Allergic Skin Manifestations.* This was followed by a period of general discussion.

The Hancock County Society feels that the Maine Medical Association should proceed as usual and elect new officers for the ensuing year.

Respectfully submitted,

J. H. Crowe, M. D.,
Secretary.

Kennebec

The May meeting of the Kennebec County Medical Association was held at the Elmwood Hotel, Waterville, Maine, May 9, 1945.

At 7:45 P. M., following dinner, the meeting was called to order by President Thomas McCoy. The minutes of the last meeting was read and approved.

Communications from the State Secretary were read, one calling attention that in view of the fact that the Annual Meeting of the State Medical Society had been called off there would be held in its place instead a meeting of the House of Delegates to elect officers and that it was desirous to have an expression of opinion of each County Society as to their feelings relative to new officers being elected or of present officers being retained.

On motion duly seconded it was voted by the Kennebec County Medical Society to favor the election of new officers. This action was taken in view of the precedent established during the First World War.

The second letter from Dr. Frederick Carter had to do with the Honorary Membership and the Maine Medical Association's Fifty-Year Service Medal to be awarded to Dr. George R. Campbell of Augusta, Maine. This action was duly acted upon by the County Society and referred to the State Secretary for action by the State Council.

Dr. Thomas McCoy then read a letter from Dr. Eugene Holt, Jr., of Portland, Maine, recommending Mr. Eldridge Smith representing the Commercial Casualty Insurance Company. Mr. Smith was presented at the meeting and spoke briefly relative to his insurance plan. After some discussion it was duly voted that the insurance plan presented by Mr. Smith be referred to the Council of the Kennebec County Medical Association with power to act.

Dr. Damesheck of the Pratt Diagnostic Hospital, Boston, Massachusetts, then gave an interesting and instructive talk on "Hematologic Problems in General Practice." His talk was supplemented by graphs and slides. He spoke well and covered many hematologic problems which arise from day to day.

Following a period of discussion Dr. Damesheck was given a rising vote of thanks.

There were thirty-five members and guests present.

Meeting adjourned at 9:45 P. M.

Respectfully submitted,

Clair S. Bauman, M. D.,
Secretary.

Lincoln-Sagadahoc

The annual meeting of the Lincoln-Sagadahoc County Medical Society was held April 26, 1945, at the Hotel Sedgwick, Bath, Maine.

The following Officers were elected:

President, Francis A. Winchenbach, M. D., Bath.

Vice President, Philip O. Gregory, M. D., Boothbay Harbor.

Secretary-Treasurer, William A. Purinton, M. D., Bath.

Delegate to the 1945 House of Delegates meeting of the Maine Medical Association: James W. Laughlin, M. D., Newcastle. Alternate: Warren E. Kershner, M. D., Bath.

Board of Censors: Drs. E. M. Pratt, E. M. Fuller, Jr., and Robert W. Belknap.

Cases were presented and discussed by the members present.

It was voted to hold a joint meeting with the Knox County Medical Society.

There were twelve members present.

Respectfully submitted,

W. A. Purinton, M. D.,
Secretary.

Resolutions

Resolutions of the Lincoln-Sagadahoc County Medical Society relative to the late

Langdon Trufant Snipe.

Time and tide wait for no man.

The Supreme Architect had given the signal and our friend has departed to that undiscovered country from whose bourne no traveler has returned.

He had rounded out a career of usefulness along those lines most congenial to him.

He was particularly interested in Social Diseases and was a pioneer anent this subject which is so vital to our Civilization and Posterity; and which has only recently come to be recognized as of paramount importance to all civilized communities.

He especially enjoyed good books, art and travel.

On his return from some of his sojourns abroad all who were fortunate enough to listen to his interesting depiction of the people, paintings, cathedrals, et al, were enthusiastic.

He will be missed by all who have been associated with him.

He was honored on many occasions by the medical profession; as a Past President of the Maine Medical Association; and for many years served as President of the Staff of the Bath Memorial Hospital. He was

a regular attendant at all medical meetings; prompt and giving freely of his knowledge, advice and counsel.

It is our desire that these resolutions be published in the *Bath Daily Times;* that a copy be sent to Mrs. Snipe; and that a copy be spread upon our records.

Respectfully submitted,

Warren E. Kershner,
E. M. Fuller, Sr.,
Committee of the Society.

Penobscot

On Tuesday, May 15th, the Penobscot County Medical Association held its regular meeting at the Bangor House, Bangor, Maine. Following dinner, Robert R. Linton, M. D., Assistant Surgeon at the Massachusetts General Hospital and Instructor in Surgery at Harvard Medical School, presented a series of lantern slides and Kodachrome moving pictures describing *Surgery of the Major Veins and Arteries.* The presentation was unusually interesting and held the close attention of those who were in attendance; 51 in number.

Respectfully submitted,

Forrest B. Ames, M. D.,
Secretary.

Washington

A meeting of the Washington County Medical Society was held at the St. Croix Hotel, Calais, Maine, on April 24, 1945. Dinner was served at 7:00 P. M., after which the meeting was called to order by the President, Walter N. Miner, M. D., of Calais. Perley J. Mundie, M. D., was elected Censor for three years. James C. Bates, M. D., of Eastport, was elected as delegate to represent the Society at the 1945 House of Delegates meeting of the Maine Medical Association.

Each member was requested to present a case, and many interesting and instructive discussions followed.

Ten members and two guests were present. The guests were Lt. Comdr. Garrett D. Duryea, and Lt. Augustus W. Sainsbury, both of Quoddy.

The meeting was adjourned at 9:30 P. M.

Respectfully submitted,

Allen H. Knapp, M. D.,
Secretary.

New Members In Military Service

Hancock

Dwight Cameron, M. D., Northeast Harbor, Maine

Notices

Annual Meeting Maine Medico-Legal Society

The annual meeting of the Maine Medico-Legal Society will consist only of a business meeting of the Executive Committee.

The Committee will meet in the evening, June 24th, at the Augusta House. Probably there will be a dinner in a small dining room, and as many Medical Examiners and County Attorneys as are available will be invited.

George L. Pratt, M. D.,
Secretary.

Hospital Staff Meetings Open to the Profession

Cary Memorial, Caribou	1st Wednesday
Central Maine General, Lewiston	1st Monday
Eastern Maine General, Bangor	2nd Tuesday
Goodall Memorial, Sanford	2nd Monday
Knox County, Rockland	1st Monday
Maine General, Portland	2nd Friday
Miles Memorial, Damariscotta	1st Thursday
Presque Isle General, Presque Isle	1st and 3rd Tuesdays
Rumford Community, Rumford	4th Wednesday
Sisters Hospital, Waterville	2nd Tuesday
St. Mary's General, Lewiston	2nd Monday
Thayer, Waterville	Every Thursday
Waldo County, Belfast	2nd Friday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

The National Foundation for Infantile Paralysis

The increased use of physical therapy in rehabilitation of the war wounded and in treatment of infantile paralysis and many other diseases and injuries is responsible for the shortage of qualified physical therapists throughout the country, declared Mr. William P. Shapleigh, Maine State Representative for The National Foundation for Infantile Paralysis, in an appeal for applicants for the National Foundation's physical therapy scholarships.

The National Foundation has appropriated $1,267,600 for a national training program, including scholarships covering courses of from nine months to one year at leading universities and medical schools throughout the country.

Applicants must have two years of college, with twelve semester units in biology and other basic sciences, or be graduates of accredited nursing or physical education schools, said Mr. Shapleigh. Those with the proper prerequisites should apply to the National Foundation, 120 Broadway, New York 5, N. Y.

"Physical therapy offers a lifetime career in an uncrowded profession," said the State Representative. "Acceptance of a scholarship puts the student under no obligation to specialize in infantile paralysis cases upon graduation. The training program aims at having an adequate number of physical therapists in all parts of the country, to meet the various needs. Such a pool of professional skill will be of particular advantage to us in Maine in the event of an epidemic."

Continued on page 115

Legislation of Interest to M. D.'s, Enacted 1945 Maine Legislature

By Herbert E. Locke, Counsel, Maine Medical Association

The following were passed by the Legislature:

1. Legislative Document 44. Public Laws 1945, Chapt. 15. An act relating to the definition of chiropractic service. Simply adds hydrotherapy and diet to the definition of the practice of chiropractic contained in R. S., c. 65, Sec. 12.

2. L. D. 45, c. 17. An act relating to the use of the prefix "Dr." by chiropractors. Permits chiropractors to "prefix the title 'Doctor' or the letters 'Dr.' to his name when accompanied by the word 'Chiropractor'." Exactly the same as with the osteopath. Some M. D.'s are inclined to object to this on the ground that it causes the prospective patient to confuse the chiropractor with M. D.'s, to believe he is consulting an M. D. instead of a chiropractor. It was the general legislative view, however, that the title "Doctor" is used for so many classifications today that the mere use of the word "Doctor" no longer indicates M. D. as such. That, anyway, patients consulting osteopaths, chiropractors, naturopaths, etc., or other cultists do so intentionally and with full knowledge of the fact that they are not consulting M. D.'s. And that, in any event, the requirement of the use of the word "Chiropractor" when the word "Doctor" is used saves any question on the point.

3. L. D. 46, c. 16. An act relating to the examination of applicants for the practice of chiropractic. In addition to anatomy and other subjects heretofore required in the list of examination subjects, there is added electrotherapy, hydrotherapy, and dietetics. This is a companion bill to No. 1 above, L. D. 44.

4. L. D. 52, c. 12. An Act relating to the educational requirements for chiropractic qualifications. Changes from 6 to 8 months the school year, 4 school years now being required and requires a total of thirty-six hundred school hours instead of the previous twenty-six hundred.

5. L. D. 53, c. 14. An act relating to terminology on certification for the practice of chiropractic. Present statute authorizes a certificate designating the holder thereof "as a doctor of chiropractic." This adds the words "or chiropractor."

6. L. D. 73, subsequent new draft L. D. 1064. C. 265. An act to provide for training and licensing nursing attendants. This law recognizes "licensed nursing attendants, L. N. A.", provides for their training, in approved hospitals and schools, and their licensing by the Board of Registration of Nurses of the state. It was considered that there was a real demand for the licensing of those who do nursing but are not R. N.'s. This bill had the scrutiny and passed with the approval of the Maine Nurses Association and its counsel.

7. L. D. 74, c. 155. An act relating to the registration of nurses. This completely revises the law for the registration of nurses. Necessity of such revision was brought to the forefront by the unfortunate nurses strike in the Maine Eye and Ear Infirmary in 1943. The Board consists of 5, appointed from a list submitted by the Maine State Nurses Association. An educational secretary and inspector of schools of nursing, one individual, is provided for. Requirements for examination and for transfer from one accredited school of nursing to another are provided. Particular provision is made for procedure in connection with cancellation or suspension of registration. An "approving committee" for acceptable schools of nursing consists of the Board of Registration of Nurses, the Commissioner of Education of the State Ex-Officio, and a business or professional man who is on the governing board of some hospital of the state. Funds accumulated by the Board and not needed for other purposes may be devoted to "the promotion of nursing education and the standards of nursing care in this state."

8. L. D. 220, new draft L. D. 1063. C. 355. An act relating to licensing hospitals and related institutions in the State of Maine. All "institutions for the hospitalization and/or nursing care of human beings" must be licensed by the Bureau of Health after inspection.

9. L. D. 226, c. 69. An act to promote proper recording and education concerning vital statistics. Beginning in the fall of 1945, every child enrolling for the first time in school must present a birth certificate.

10. L. D. 436, new draft L. D. 1182. C. 341. An act requiring school employees to file health certificates. Any school employee "who comes in direct contact with the students of any public school" must file with the local school committee a doctor's certificate of examination, with freedom "from all communicable and infectious diseases," cost to be borne by the State Department of Education. And for failure to do so, he forfeits his or her salary until he does do so.

11. L. D. 467, c. 180. An act relating to prevention of blindness. Makes mandatory the "installation into the eyes of the infant immediately upon its birth, one or two drops of a prophylactic solution" prescribed and provided without cost by the Department of Health. Heretofore, this was waived if "either parent or guardian of the infant shall offer conscientious objection thereto." Imposes fine of not more than $100 or imprisonment for not more than 6 months upon "physician, midwife or nurse in charge of said infant" who fails to do so.

12. L. D. 469, new draft L. D. 1129. C. 313. An act relating to examination and registration of osteopathic physicians. As proposed in L. D. 469, it provided for osteopaths to "participate in health services under the Department of Health and Welfare." This failed to pass. But the provision authorizing osteopaths to "sign certificates for committing persons to state institutions" did pass.

13. L. D. 470, c. 181. An act relating to premarital medical examinations. "A detailed report of the laboratory tests* shall be transmitted by the laboratory to the physician, who, after examining it, shall file it with the Bureau of Health, and it shall be held in (absolute) confidence and shall not be open to public inspections." "Absolute" is stricken out. The Attorney General's Department felt that the use of the word "absolute" could be construed to prevent even the Department itself making proper use of the information. And that the use of the word "confidence" without this adjective "absolute" did not do so but would accomplish the freedom from public inspection which the statute contemplated.

14. L. D. 472, c. 351. An act relating to local health officers. Revises the local health officer law completely.

15. L. D. 474, c. 295. An act relating to contagious diseases. Strikes out venereal diseases from Sec. 61 which provides for the physician to notify the local health officer in cases of "notifiable diseases." Because the report of venereal diseases is covered by another section, Sec. 90, with a different procedure. This merely clarifies a possible confusion in existing law.

Continued on page 115

Councilor Reports

Report of Councilor, First District

To the Officers and Members of the Maine Medical Association:

York and Cumberland County Medical Societies have held the regular meetings during the year.

The program of each meeting has been so arranged as to be of practical help to all the members. The attendance at each meeting has been more than last year and this is very encouraging to the officers of the Societies who are endeavoring to promote an interest in the meetings. It is hoped to thus keep the Societies more actively organized so that members returning from the service will not feel that we have fallen down on the job.

Respectfully submitted,
E. Eugene Holt, Jr., M. D.,
Councilor, First District.

Report of Councilor, Second District

To the Officers and Members of the Maine Medical Association:

There is nothing specific to report from any of the three County Societies of the Second District. Occasional meetings have been held, sufficiently often, to transact and act upon matters of interest to each Society. Attendance at each of these meetings was small. This is what one would expect as the result of still increased work thrust upon the remaining few doctors. It is my feeling, that each County is aware of the importance of having these meetings, which, after all, constitute the back bone of the State Society. It is hoped that by another year, some of our doctors will have returned from Service, which, in turn, will increase the attendance at the various County meetings. Surely, their presence will be the means of a great stimulus and all will be heartily welcomed by us again.

Respectfully submitted,
Currier C. Weymouth, M. D.,
Councilor, Second District.

Report of Councilor, Third District

To the Officers and Members of the Maine Medical Association:

The Councilor for the Third District reports that the Lincoln-Sagadahoc Society has held three meetings this year. They have lost one member by death and acquired no new members.

The Knox County Society has held meetings monthly. They have acquired three new members and lost one by death. On June 12th the Society will be host to a joint meeting with the Lincoln-Sagadahoc Society and the Waldo County Society. There will be a late afternoon clinic with address in the evening by Dr. Samuel Proger of Boston.

Respectfully submitted,
C. Harold Jameson, M. D.,
Councilor, Third District.

Report of Councilor, Sixth District

To the Officers and Members of the Maine Medical Association:

As Councilor for the Sixth District of the Maine Medical Association I have a very brief report to present.

I have no official report from the Aroostook County Society but during the past year have had professional contact with various members of that group and know that they are carrying on very well.

From the Piscataquis County Association I have word that four regular meetings have been held during the past year. At the November meeting, Roscoe L. Mitchell, M. D., Director of the Bureau of Health for Maine, presented a paper. Other meetings were routine.

The Penobscot County Association has held its usual eight meetings during the past year. Some of these meetings were held in coöperation with the War-Time Graduate Medical Service and speakers were furnished by the New England Committee. Members of the Armed Forces stationed at Dow Field in Bangor joined us for these meetings.

Respectfully submitted,
Forrest B. Ames, M. D.,
Councilor, Sixth District.

Committee Reports

Standing Committees

Public Relations Committee

To the Officers and Members of the Maine Medical Association:

The activity of the Public Relations Committee has been confined mostly to conferences with Norman C. Fitzpatrick, State Director of War Food Administration relative to the prescribing of heavy cream.

Early in the year I received a request from Dr. R. V. N. Bliss, President of the Maine Medical Association, asking that I suggest three doctors in this vicinity who would confer with the OPA from time to time regarding increased food in certain medical and surgical diseases. Dr. Leon D. Herring of Winthrop and Doctors A. J. Gingras and William J. O'Connor of Augusta were appointed and they have held several conferences with OPA officials.

Roland L. McKay, M. D.,
Chairman.

Social Hygiene Committee

To the Officers and Members of the Maine Medical Association:

I hereby submit my report as Chairman of the Social Hygiene Committee for the year 1944-45.

Since the last June session at Rockland, where the House of Delegates went on record as being opposed to certain sections of the present Venereal Disease Law, there has been a definite endeavor on the part of our President, Dr. Bliss, members of the Social Hygiene Committee, and our legal adviser, Mr. Locke, to have this legislation rectified.

Trying to overcome the possible legal entanglements, which Mr. Locke pointed out in the May, 1943 issue of the MAINE MEDICAL JOURNAL, and also to obviate class discrimination in reporting venereal disease cases, the above mentioned members with Mr. Locke's advice formulated such amendments which would overcome the objectionable sections of the present law. These amendments were presented to the proper committee at the recent Legislature.

Unfortunately the amendments were defeated in the House on the grounds of "invasion of constitutional rights." Why were these same "constitutional rights" challenged two years ago when our present law was passed? Therefore, today, some American citizens, who are in no way responsible for their infection, must suffer unusual humiliation because of legislative acts. Is the voice of the Maine physician in legislature becoming weaker and weaker each year?

Respectfully submitted,

O. R. JOHNSON, M. D.,
Chairman.

Special Committees

Committee on Graduate Education

To the Officers and Members of the Maine Medical Association:

The Committee on Graduate Education submits the following report for 1944-45.

The work of the committee has been necessarily curtailed because of the War. With practically all of our younger men in Service, greatly increased burdens have devolved upon the older men left in civilian practice (average age in Maine, 62). To a large extent the activities of the committee have been confined to planning for the Post-War Period.

It is obvious that there will be a great demand for Graduate Education after the War. Most of the recent graduates will require considerable post-graduate study to round out their training and to make up for the deficiencies of the accelerated medical school programs. And many of the older men will feel the need of further implementing their medical education before returning to civilian practice. Information regarding residencies in the different specialties and refresher courses has been compiled and will be available to these returned veterans.

The Fellowships offered through the Bingham Associates have been of tremendous value to our physicians. Thirteen of our members took such courses during the year. With the return of our younger men there will be a greater demand for these excellent opportunities for post-graduate study.

Your committee feels that one of the best means of extending opportunities in Continuation Education is in the development of regular hospital staff meetings into clinical meetings with programs of teaching value, open to the profession in general. Many hospitals are already conducting such meetings; many more should institute them. Your committee has compiled a list of regularly held staff meetings through information obtained from the Maine Hospital Association, which is to be carried in the JOURNAL and added to or corrected from time to time. It is hoped that this will stimulate attendance and help develop this excellent means of Continuation Education.

Your chairman has served on the New England Committee for War Time Graduate Medical meetings and several of our members have presented papers and conducted clinics at the different military installations in our State.

Early in the year the committee lost two members. Dr. James Carswell, of Camden, left the State for extended graduate study, and Dr. Frank Jackson, of Houlton, who had rendered valuable service since its inception, felt obliged to resign because of demands of his practice.

Respectfully submitted,

THOMAS A. FOSTER,
JULIUS GOTTLIEB,
E. EUGENE HOLT, JR.,
LEROY H. SMITH,
FREDERICK T. HILL, *Chairman.*

Committee to Survey Hospital and Medical Care

As you know, this Committee recommended to the House of Delegates an investigation of the Massachusetts Plan for Prepaid Medical Care. The Council appointed a committee which presented a modification of this plan. Their proposal was unanimously rejected by the various component societies.

A mail canvass of the members of the committee elicited the opinion that no other proposition had yet been presented which would be likely at this time to receive more favorable consideration. In view of transportation difficulties, therefore, meeting was postponed.

S. JUDD BEACH, M. D., *Chairman.*
FRANKLIN A. FERGUSON, M. D., *Sec'y.*
GERALD R. SMITH, M. D.
GEORGE L. PRATT, M. D.
WARREN E. KERSHNER, M. D.
EDWARD H. RISLEY, M. D.
WILLARD H. BUNKER, M. D.
CLYDE I. SWETT, M. D.
ROSCOE L. MITCHELL, M. D.

Tuberculosis Committee

Mr. President, and Members of the Maine Medical Association:

Through the kind invitation of Dr. Cromwell, the Tuberculosis Committee of the Maine Medical Association held a meeting on August 4, 1944, at the Central Maine Sanatorium, as it seemed to be centrally located for most of the members of the Committee. Following the three-hour discussion, a delightful dinner was served in the patients' dining room, where the talk was continued.

Dr. Mitchell of the Maine Department of Health was present to speak about the proposed federal grant to the state to aid in the control of tuberculosis. He gave a brief outline to the effect that about $10,000,000 was proposed in all, to establish a tuberculosis division of the United States Public Health Service, and also to be allocated to each state in proportion to the population. He pointed out that the function of the Federal Service was merely advisory and not control of treatment of patients. The state is now setting up a Kardex system containing pertinent facts about patients. These will also include such data as date of next X-ray and

check-up, with which the Department of Health will assist through its nurses, and even provide transportation where necessary. These records are acceptable to the U. S. Public Health Service as well as our methods of control.

The subject next under discussion was the positive patient who left the sanatorium against advice. Dr. Locklin quoted the Illinois law which requires automatic quarantine of all patients on arrival at a sanatorium. This continues as long as the sputum remains positive. No one can break the quarantine, nor can anyone go to a home where there are children under sixteen so long as he remains a menace, or if the home is unsuitable. Inspection of the home is part of the work of the medical social worker.

Mention was made of quarantine at the state sanatoria of at least the uncoöperative positive sputum cases, but nothing can be done right now because of lack of personnel and proper detention type of buildings. However, the entire committee agreed that some such control was a "must" as soon as possible.

The subject of medical social workers, one to each sanatorium, was also brought up, but it appears as though a large amount of work is already being done by the Department of Health through its nursing service. As far as such a social worker is concerned, there is little likelihood of being able to obtain one now because of scarcity of personnel and funds.

It was also brought out at the meeting that physicians throughout the state do not, as a whole, report their cases of tuberculosis. Most of the data obtained is now coming from the state sanatoria, even though all such cases first pass through the physicians' hands. To properly control this disease, it is necessary that every case be reported.

In addition to the above, which were usually by unanimous consent, the committee voted to advise Dr. Mitchell to go after the Federal Funds in order to put on a larger case finding program.

Although only the one meeting was officially held, your chairman has many times met members of the committee, and he has been urged by several to include in his report the following points:

1. The establishment of a preventorium to get the almost sick children back on their feet. This would be much less expensive than treatment of active tuberculosis.

2. The establishment of the state sanatoria under the direct control of the Department of Health. This is the request of numerous physicians throughout the state.

3. The formation of County Medical Society T. B. Committees to report directly to the county societies.

This report should not be closed without mention of the talk by Dr. Hilleboe, Chief of the Tuberculosis branch of the U. S. Public Health Association, at Western Maine Sanatorium, April 24, 1945. He urged that all healthy people be X-rayed to find the early case, as the known cases are already well worked out. Since most cases today come from an apparently healthy family, the use of routine chest plates on admission to a general hospital, like routine laboratory work, would bring many cases to light. The use of 35 mm. film would keep down the cost.

Dr. Hilleboe, both before and during the meeting, emphasized strongly that the Federal Service is merely advisory. Each state is urged to continue its present method of control, which in Maine was classified as "Excellent." The only suggestions made were the routine admission chest plates, and a more thorough record system, especially of the known case of tuberculosis so that, at any time, the Board of Health could put its finger on the condition and location of the case.

I wish to thank the busy members of the Tuberculosis Committee for their hearty coöperation and support. The restrictions on travel and the lack of time of these busy members have alone prevented more than the one meeting.

Respectfully submitted,

WALTER R. GUMPRECHT, M. D.,
Chairman.

Committee on Maternal and Child Welfare

To the Officers and Members of the Maine Medical Association:

The Committee on Maternal and Child Welfare regrets to report that it has been unable to do any work this year. None of the members were able to give the necessary time.

Respectfully submitted,

ALBERT W. FELLOWS, M. D.,
Chairman.

Committee on Industrial Health

To the Officers and Members of the Maine Medical Association:

Due to existing travel conditions and to mileage involved between its members, the committee on Industrial Health has felt it inadvisable to hold a meeting. However, a general survey of industrial plants indicates conditions well stabilized and there appears to be no shortage of medical or nursing personnel.

Your committee hopes to meet with the State Industrial Committee in September, when men doing industrial work may meet the said State Committee, and it is hoped that at this joint meeting we may be advised of problems confronted by industry and also hear from men doing special work in this field.

Respectfully submitted,

HAROLD W. STANWOOD, M. D.,
Chairman.

Report of the Secretary

To the Officers and Members of the Maine Medical Association:

As your Secretary I am pleased to submit the following report:

There are 726 members in good standing in the Association; 506 Active, 186 in Military Service, and 34 Honorary. Twelve new members have been added to the roster during the past year, and five re-instated to membership. Eighteen members have died since May 31, 1944, three have resigned because of ill health, and three have moved out of the State and transferred their memberships. 100% payment of dues has been received from eleven county societies; there being only four members whose 1945 dues remain unpaid.

In accordance with a ruling from the Office of Defense Transportation the Council, on April 22, 1945, voted to cancel the annual meeting which was to have been held June 24th, 25th, and 26th, at the Poland Spring House, and to hold in its place a one-day meeting of the House of Delegates. Order of Business for this one-day business meeting, which will be held on Sunday, June 24th, at the Augusta House, Augusta, Maine, will be found elsewhere in this issue. It is extremely important that each delegate, or his alternate, be present at this meeting.

Fifty years ago, four of our members were graduated from Bowdoin Medical School and are, therefore, eligible to Honorary Membership and the Association's Gold Medal in recognition of these years of service in their chosen profession. It has been customary to present these medals at the Annual Banquet, a ceremony that was looked forward to, and enjoyed, by all present —but this year, because of the cancellation of the annual meeting, the medals will be mailed to the following: Wallace W. Webber, M. D., Lewiston (Androscoggin County); Benjamin Lake Noyes, M. D., Stonington, (Hancock County); George R. Campbell, M. D., Augusta (Kennebec County); Amos E. Small, M. D., Bangor (Penobscot County). I wish to extend to these members my sincere best wishes for the years ahead.

The work of the Association could not go on if it were not for the Officers of the County Societies, and Councilors and Officers of the State Association, and I hereby express to these members my sincere appreciation for their coöperation during the past year. Also to all other members, Active, Military and Honorary, each of whom has coöperated to the fullest extent in whatever role has been his to play.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Secretary.

May 31, 1945.

Report of the Treasurer

To the Officers and Members of the Maine Medical Association:

As your Treasurer I wish to make the following report:

The financial standing of the Association and JOURNAL is sound. The complete report of Jordan and Jordan, Accountants and Auditors, will be sent to the members of the Financial Advisory Committee before the meeting of the House of Delegates to be held June 24th, and will be published in the July issue of the JOURNAL. A copy will also be kept on file in the Portland office where it will be available to any member of the Association.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Secretary.

May 31, 1945.

In Memoriam

Members Deceased since May 31, 1944

Bennet, Eben H.,	Lubec
Bell, Charles W.,	Farmington
Bolster, William W.,	Lewiston
Burgess, Charles H.,	Bangor
Dennison, Charles N.,	Waldoboro
Fuller, Abbott J.,	Pemaquid
Geer, George I.,	Portland
Graves, Richard A.,	Presque Isle
Hay, Walter F. W.,	Portland
Hiebert, Joelle C.,	Lewiston
McDonald, John A.,	East Machias
Nichols, Estes,	Portland
Pattee, Sumner C.,	Belfast
Pierce, Edwin F.,	Lewiston
Pudor, Gustav A.,	Portland
Snipe, Langdon T.,	Bath
Swift, Henry M.,	Cape Cottage
Warren, Mortimer,	Portland

Maine Medical Association House of Delegates' Meeting
Sunday, June 24, 1945
Augusta House, Augusta, Maine

First Meeting
11.00 A. M.

Chairman — Adam P. Leighton, M. D., President-elect

Call to Order by Chairman.
Roll Call by Secretary (ten delegates a quorum).
Appoint Reference Committee (three delegates).
Appoint Nominating Committee (this Committee to draw up a slate of Standing Committee members for 1945-46, and report to the Second Meeting of the House of Delegates at 4.30 P. M.).
Report of Council for 1944-45.
Presentation of 1945-46 Budget as recommended by the Council.
Reports of Councilors (not submitted for publication in the June issue of the JOURNAL).
Reports of Standing Committees (not submitted for publication in the June issue of the JOURNAL).
Reports of Special Committees (not submitted for publication in the June issue of the JOURNAL).
New Business.

Luncheon
1.30 P. M.

Presiding: R. V. N. Bliss, M. D., President, Maine Medical Association.
Speakers:
John J. Moorhead, M. D., New York City.
Albert S. Crawford, M. D., Detroit, Michigan.

Second Meeting
4.30 P. M.

Chairman — Adam P. Leighton, M. D., President-elect

Call to Order by Chairman.
Roll Call by Secretary (ten delegates a quorum).
Report of Nominating Committee by Committee Chairman.
Report of Reference Committee by Committee Chairman.
Election of Councilors from First and Second Districts:
(First District — Cumberland and York Counties.)
(Second District — Androscoggin, Franklin and Oxford Counties.)
Unfinished Business.
New Business.

County Delegates, 1945

County Medical Societies

FIRST DISTRICT

Cumberland County

Delegates: (Two Years)
Kenneth Dore, M. D., Fryeburg.
Stephen S. Brown, M. D., Portland.
Francis J. Welch, M. D., Portland.

(One Year):
Oscar R. Johnson, M. D., Portland.
Joseph E. Porter, M. D., Portland.
Louis L. Hills, M. D., Westbrook.

Alternates: (Two Years)
Isaac M. Webber, M. D., Portland.
Waldo T. Skillin, M. D., South Portland.

(One Year):
Theodore C. Bramhall, M. D., Portland.
Harold V. Bickmore, M. D., Portland.

York County

Delegates:
Waldron L. Morse, M. D., Springvale.
James H. MacDonald, M. D., Kennebunk.
Charles W. Kinghorn, M. D., Kittery.

Alternates:
Ralph S. Belmont, M. D., Sanford.
Oscar R. Perrault, M. D., Biddeford.

SECOND DISTRICT

Androscoggin County

Delegates:
Ralph A. Goodwin, M. D., Auburn.
Ward J. Renwick, M. D., Auburn.
Daniel F. D. Russell, M. D., Leeds.

Alternates:
Albert W. Plummer, M. D., Lisbon Falls.
Blinn W. Russell, M. D., Lewiston.
Paul R. Chevalier, M. D., Lewiston.

Franklin County

Delegate:
George L. Pratt, M. D., Farmington.

Alternate:
Cecil F. Thompson, M. D., Phillips.

Oxford County

Delegates:
Garfield G. Defoe, M. D., Dixfield.
Raymond R. Tibbetts, M. D., Bethel.

Alternates:
Albert P. Royal, M. D., Rumford.
Delbert M. Stewart, M. D., South Paris.

THIRD DISTRICT

Knox County

Delegates:
C. Harold Jameson, M. D., Rockland.
Paul A. Millington, M. D., Camden.

Lincoln-Sagadahoc Counties

Delegate:
James W. Laughlin, M. D., Newcastle.

Alternate:
Warren E. Kershner, M. D., Bath.

FOURTH DISTRICT

Kennebec County

Delegates:
Clarence R. McLaughlin, M. D., Gardiner.
Herbert R. Kobes, M. D., Augusta.
Thomas C. McCoy, M. D., Waterville.
L. Armand Guite, M. D., Waterville.

Alternate:
Maurice A. Priest, M. D., Augusta.

Somerset County

Delegate:
George E. Young, M. D., Skowhegan.

Alternate:
Maurice S. Philbrick, M. D., Skowhegan.

Waldo County

Delegate:
Foster C. Small, M. D., Belfast.

Alternate:
Seth H. Read, M. D., Belfast.

FIFTH DISTRICT

Hancock County

Delegate:
James H. Crowe, M. D., Ellsworth.

Alternate:
George Parcher, M. D., Ellsworth.

Washington County

Delegate:
James C. Bates, M. D., Eastport.

SIXTH DISTRICT

Aroostook County

Delegates:
Clyde I. Swett, M. D., Island Falls.
Eugene B. Griffiths, M. D., Presque Isle.

Penobscot County

Delegates:
Leroy H. Smith, M. D., Winterport.
Samuel S. Silsby, M. D., Bangor.
Ernest T. Young, M. D., Millinocket.
Martyn A. Vickers, M. D., Bangor.

Alternates:
Hugh G. McKay, M. D., Old Town.
Asa C. Adams, M. D., Orono.
LaForest J. Wright, M. D., Bangor.

Piscataquis County

Delegate:
Fred J. Pritham, M. D., Greenville Junction.

Alternate:
Ralph C. Stuart, M. D., Guilford.

OFFICIAL ROSTER

OF THE

MAINE MEDICAL ASSOCIATION

MEMBERS

MEMBERS IN MILITARY SERVICE

HONORARY MEMBERS

MAY 31, 1945

ANDROSCOGGIN COUNTY

MEMBERS

Andrews, Sullivan L.,	138 Lisbon St., Lewiston
Barney, Maurice O.,	38 Granite St., Nashua, N. H.
Beliveau, Romeo A.,	89 Pine St., Lewiston
Bernard, Romeo A.,	144 Pine St., Lewiston
Brien, Maurice,	80 Pine St., Lewiston
Buker, Edson B.,	80 Goff St., Auburn
Busch, John J.,	105 Elm St., Mechanic Falls
Call, Ernest V.,	118 Pine St., Lewiston
Caron, Frederick J.,	174 Bates St., Lewiston
Cartland, John E.,	117 Goff St., Auburn
Chaffers, William H.,	190 Bates St., Lewiston
Chenery, Frederick L., Jr.,	Monmouth
Chevalier, Paul R.,	240 Lisbon St., Lewiston
Clapp, Roland D.,	300 Main St., Lewiston
Desaulniers, George E. D.,	106 Chestnut St., Lewiston
Desaulniers, Lucy O'C.,	92 Pine St., Lewiston
Fahey, William J.,	17 Frye St., Lewiston
Fortier, Paul J. B.,	190 Bates St., Lewiston
Gauvreau, Horace L.,	82 Pine St., Lewiston
Gerrish, Lester P.,	Lisbon Falls
Giguere, Eustache N.,	108 Cedar St., Lewiston
Goldman, Morris E.,	487 Main St., Lewiston
Goodwin, Ralph A.,	56 Dennison St., Auburn
Gottlieb, Julius,	49 Central Ave., Lewiston
Grant, Alton L., Jr.,	133 Court St., Auburn
Gross, Leroy C.,	19 Goff St., Auburn
Hanscom, Oscar E.,	Greene
Hayden, Louis B.,	Livermore Falls
Higgins, Everett C.,	149 College St., Lewiston
Hirshler, Max,	85 Pine St., Lewiston
James, Chakmakis,	133 College St., Lewiston
Marcotte, John B.,	280 Lisbon St., Lewiston
Marston, Edwin J.,	76 Goff St., Auburn
Miller, Hudson R.,	11 Turner St., Auburn
Murphy, D. Jerome,	126 College St., Lewiston
Peaslee, Clarence C.,	42 Goff St., Auburn
Poulin, J. Emile,	198 Lisbon St., Lewiston
Pratt, Harold S.,	Livermore Falls
Rand, Carleton H.,	166 College St., Lewiston
Rand, George H.,	Livermore Falls
Randall, Ray N.,	19 Sabattus St., Lewiston
Renwick, Ward J.,	102 Goff St., Auburn
Rowe, Gunthner H.,	Livermore Falls
Roy, Leopold O.,	54 Pine St., Lewiston
Russell, Blinn W.,	98 Pine St., Lewiston
Russell, Daniel F. D.,	Leeds
Schneider, George A.,	198 Lisbon St., Lewiston
Sweatt, Linwood A.,	48 Drummond St., Auburn
Thomas, Camp C.,	Greene
Twaddle, Gard W.,	57 Goff St., Auburn
Wakefield, Frederick S.,	324 Main St., Lewiston
Webber, Wallace E.,	297 Main St., Lewiston
Williams, James A.,	Mechanic Falls

HONORARY MEMBER

Plummer, Albert W.	Mechanic Falls

MEMBERS IN MILITARY SERVICE

Beeaker, Vincent,	Lewiston
Beliveau, Bertrand A.,	Lewiston
Bousquet, Jean,	Lewiston
Brooks, Glidden L.,	Lewiston
Clapp, Waldo A.,	Lewiston
Clapperton, Gilbert,	Lewiston
Corrao, Frank P.,	Lewiston
Cox, William V.,	Auburn
Frost, Robert A.,	Auburn
Greene, Merrill S. F.,	Lewiston
Haas, Rudolph,	Lewiston
Harkins, Michael J.,	Lewiston
Mandelstam, Abe W.,	Lewiston
Steele, Charles W.,	Lewiston
Tibbetts, Otis B.,	Auburn
Tousignant, Camille,	Lewiston
Viles, Wallace E.,	Turner
Webber, Wedgwood P.,	Lewiston

AROOSTOOK COUNTY

MEMBERS

Albert, Armand,	Van Buren
Albert, Joseph L.,	Fort Kent
Berrie, Lloyd H.,	Caribou
Blossom, Frank O.,	Caribou
Boone, Storer W.,	Presque Isle
Burr, Charles G.,	Houlton
Carter, Loren F.,	Presque Isle
Damon, Albert H.,	Limestone
Doble, Eugene H.,	Presque Isle
Donovan, Joseph A.,	Houlton
Ebbett, Penry L. B.,	Houlton
Faucher, Francois J.,	Grand Isle
Gehlert, Sidney R.,	Eagle Lake
Gibson, William B.,	Houlton
Gregory, Frederick L.,	Caribou
Griffiths, Eugene B.,	Presque Isle
Grow, William B.,	Presque Isle
Hammond, H. Herbert,	Van Buren
Harvey, Thomas G.,	Fort Fairfield
Huggard, Leslie H.,	Limestone
Jackson, Frank H.,	Houlton
Kalloch, Herbert F.,	Fort Fairfield
Kimball, Herrick C.,	Fort Fairfield
Kirk, William V.,	Eagle Lake
Labbe, Onil B.,	Van Buren
LaPorte, Paul C.,	Edmundston, N. B.
Larrabee, Fay F.,	Washburn
Levesque, Romeo,	Frenchville
Savage, Richard L.,	Fort Kent
Somerville, Robert B.,	Presque Isle
Somerville, Wallace B.,	Mars Hill
Swett, Clyde I.,	Island Falls
Webber, John R.,	Houlton

HONORARY MEMBERS

Dobson, Lindley,	Presque Isle
Sincock, Wiley E.,	Caribou
Upton, George W.,	Sherman Mills

MEMBERS IN MILITARY SERVICE

Donahue, Gerald H.,	Presque Isle
Ebbett, George H.,	Houlton
Gagnon, Bernard,	Houlton
Gormley, Eugene G.,	Houlton
Toussaint, Leonid G.,	Fort Kent

CUMBERLAND COUNTY

MEMBERS

Allen, John H.,	Pond Cove, Cape Elizabeth
Asali, Louis A.,	29 Deering St., Portland
Babalian, Leon,	32 Deering St., Portland
Barker, Nathaniel B. T.,	Yarmouth
Beach, S. Judd,	704 Congress St., Portland
Beck, Henry W.,	Gray
Bickmore, Harold V.,	723 Congress St., Portland
Bishoffberger, John M.,	Naples
Bishop, Lloyd W.,	211 Vaughan St., Portland
Bramhall, Theodore C.,	704 Congress St., Portland
Brown, Luther A.,	13 Deering St., Portland
Brown, Stephen S.,	22 Arsenal St., Portland
Burrage, Thomas J.,	142 High St., Portland
Burns, Robert,	Windham
Cappello, Joseph,	144 Spring St., Portland
Carmichael, Frank E.,	72 Deering St., Portland
Center, Ervin A.,	Steep Falls
Clarke, Chester L.,	10 Congress Square, Portland
Clough, Dexter J.,	10 Dow St., Portland

Conneen, Lawrence W.,	131 State St., Portland
Cragin, Charles L.,	831 Congress St., Portland
Cummings, George O.,	47 Deering St., Portland
Curtis, Harry L.,	142 High St., Portland
Davidson, David,	45 Deering St., Portland
Davidson, Gisela K.,	45 Deering St., Portland
Davis, Harry E.,	169 State St., Portland
Dyhrberg, Norman,	Gorham
Dionne, Maurice J.,	Brunswick
Dooley, Francis M.,	53 Deering St., Portland
Dore, Kenneth E.,	Fryeburg
Dorsey, Frank D.,	52 Deering St., Portland
Drummond, Joseph B.,	62 State St., Portland
Dyer, Henry L.,	27 Green Sq., Berlin, N. H.
Emery, Harry S.,	721 Stevens Ave., Portland
Everett, Harold J.,	308 Danforth St., Portland
Ferguson, Franklin A.,	9 Deering St., Portland
Fickett, Jerome P.,	Naples
Files, Ernest W.,	201 State St., Portland
Fisher, Stanwood E.,	388 Spring St., Portland
Folsom, Ernest B.,	37 Payson St., Portland
Foster, Albert D.,	Bay Shore Drive, Falmouth Foreside
Foster, Benjamin B.,	300 Danforth St., Portland
Foster, Thomas A.,	131 State St., Portland
Gehring, Edwin W.,	131 State St., Portland
Gordon, Charles H.,	46 Deering St., Portland
Gould, Arthur L.,	Freeport
Hall, Earl S.,	696 Congress St., Portland
Hamel, John R.,	50 Deering St., Portland
Haney, Ormel E.,	74 Deering St., Portland
Hanson, Henry W., Jr.,	Cumberland Center
Haskell, Alfred W.,	142 High St., Portland
Hatch, Lucinda B.,	27 Deering St., Portland
Hawkes, Richard S.,	201 State St., Portland
Hills, Louis L.,	816 Main St., Westbrook
Holt, E. Eugene, Jr.,	723 Congress St., Portland
Holt, William,	14 Deering St., Portland
Huntress, Roderick L.,	10 Congress Sq., Portland
Jamieson, James G. S.,	82 High St., Portland
Johnson, Henry P.,	32 Deering St. Portland
Johnson Oscar R.	18 Deering St., Portland
Kupelian, Nessib S.,	Pownal
Lamb, Henry W.,	131 State St., Portland
Lappin, John J.,	171 State St., Portland
Leighton, Adam P.,	192 State St., Portland
Little, Albion H.,	692 Congress St., Portland
Logan, G. E. C.,	131 State St., Portland
Lothrop, Eaton S.,	690 Congress St., Portland
Macdonald, H. Eugene,	201 State St., Portland
Martin, Ralf S.,	58 Deering St., Portland
Martin, Thomas A.,	131 State St., Portland
McAdams, William R.,	704 Congress St., Portland
McDermott, Leo J.,	171 Vaughan St., Portland
Melnick, Jacob,	333 Congress St., Portland
Miller, Thor,	752 Main St., Westbrook
Monkhouse, William M.,	62 Bowdoin St., Portland
Morrison, James B.,	582 Main St., Westbrook
Moulton, Albert W.,	180 State St., Portland
Needelman, William R.,	312 Congress St., Portland
O'Donnell, Eugene E.,	32 Deering St., Portland
Parker, James M.,	31 Deering St., Portland
Patterson, James,	614 Highland Ave., So. Portland
Peaslee, C. Capen, Jr.,	539 Woodford St., Portland
Peters, Clinton N.,	10 Congress Sq., Portland
Pingree, Harold A.,	131 State St., Portland
Porter, Joseph E.,	22 Arsenal St., Portland
Richardson, Clyde E.,	Brunswick
Ridlon, Magnus G.,	Kezar Falls
Robinson, Carl M.,	31 Deering St., Portland
Rowe, Daniel M.,	757 Congress St., Portland
Santoro, Domenico A.,	201 State St., Portland
Sawyer, Samuel G.,	Cornish
Scolten, Adrian H.,	32 Deering St., Portland
Shanahan, William H.,	306 Congress St., Portland
Skillin, Waldo T.,	87a Ocean St., So. Portland
Smith, Frank A.,	343 Main St., Westbrook
Stetson, Elbridge G. A.,	Brunswick
Stevens, Theodore M.,	32 Deering St., Portland
Stuart, Albert F.,	U. S. Marine Hosp., Portland
Sulkowitch, Hirsh,	188 State St., Portland
Szanton, Victor L.,	Jackman Station
Tetreau, Thomas,	44 Monument St., Portland
Thaxter, Langdon T.,	31 Deering St., Portland
Thompson, Philip P.,	704 Congress St., Portland
Tibbetts, George A.,	519 Cumberland Ave., Portland
Tobie, Walter E.,	3 Deering St., Portland
Ulpts, Reynold G. E.,	83 West St., Portland
Upham, Roscoe C.,	15 Crescent St., Biddeford
Walker, Maribel H.,	Cape Cottage
Ward, John V.,	131 State St., Portland
Webb, Harold R.,	Brunswick
Webber, Isaac M.,	29 Deering St., Portland
Webber, M. Carroll,	735 Stevens Ave., Portland
Webster, Fred P.,	10 Congress Sq., Portland
Weeks, DeForest,	158 Pleasant Ave., Portland
Welch, Francis J.,	44 Deering St., Portland
Wellington, J. Foster,	655 Congress St., Portland
Wescott, Clement P.,	201 State St., Portland
Whitney, Harlan R.,	655 Congress St., Portland
Whittier, Alice A. S.,	143 Neal St., Portland
Wight, Donald G.,	30 Mitchell Rd., So. Portland
Williams, Ralph E.,	Freeport
Wilson, Clement S.,	Brunswick
Woodman, Arthur B.,	Falmouth Foreside
Zolov, Benjamin,	296 Congress St., Portland

HONORARY MEMBERS

Bradford, William H.,	133 Coyle St., Portland
Brock, Henry H.,	Alfred
Howard, Harvey,	Freeport
Marshall, Bertrand F.,	813 Main St., Westbrook
Pepper, John L.,	960 Sawyer St., So. Portland
Robinson, Edward F.,	Falmouth
Wheet, Frederick E.,	773 Main St., Westbrook

MEMBERS IN MILITARY SERVICE

Blaisdell, Elton R.,	Portland
Branson, Sidney R.,	So. Windham
Casey, William L.,	Portland
Christensen, Harry E.,	Portland
Clancey, Daniel J.,	Portland
Daniels, Donald H.,	Portland
Davis, Paul V.,	Bridgton
Douphinett, Otis J.,	Portland
Drake, Eugene H.,	Portland
Dunham, Carl E.,	Portland
Fagone, Francis A.,	Portland
Finks, Henry B.,	Portland
Fogg, C. Eugene,	Portland
Getchell, Ralph A.,	Portland
Geyerhahn, George,	So. Portland
Greco, Edward A.,	Portland
Ham, Joseph G.,	Portland
Hanlon, Francis W.,	Portland
Hebb, Henry S.,	Bridgton
Heifetz, Ralph,	Portland
Holt, C. Lawrence,	Portland
Hynes, Edward A.,	So. Portland
Johnson, Albert C.,	Portland
Johnson, Gordon N.,	Portland
Laughlin, K. Alexander,	Portland
Leighton, Wilbur F.,	Portland
Lombard, Reginald T.,	So. Portland
Love, Robert B.,	Gorham
Lovelace, Daniel D., Jr.,	Gorham
Marston, Paul C.,	Kezar Falls
McCrum, Philip H.,	Portland
McLean, E. Allan,	Portland
McManamy, Eugene P.,	Portland
Moore, Roland B.,	Portland
Morrison, Alvin A.,	Portland
Munro, Burton S.,	Berlin, N. H.

Ottum, Alvin E.,	Portland
Poore, George C.,	Portland
Sapiro, Howard M.,	West Scarboro
Schwartz, Carol,	Portland
Simecek, Victor H.,	Brunswick
Smith, Kenneth E.,	Portland
Spencer, Jack,	Portland
Tabachnick, Henry M.,	Portland
Thompson, Milton S.,	Portland
Tougas, Raymond,	Brunswick

FRANKLIN COUNTY

MEMBERS

Arms, Burdett L.,	Farmington
Croteau, J. Thomas	Chisholm
Dunlap, Clarence J.,	Kingfield
Floyd, Albion E.,	New Sharon
Kyes, Preston,	North Jay
Moulton, John H.,	Rangeley
Pratt, George L.,	Farmington
Thompson, Cecil F.,	Phillips
Weymouth, Currier C.,	Farmington
Zikel, Herbert M.,	Wilton

HONORARY MEMBER

White, Verdeil O.,	East Dixfield

MEMBERS IN MILITARY SERVICE

Brinkman, Harry,	Farmington
Colley, Maynard B.,	Wilton
LaTourette, Kenneth A.,	Farmington
Reed, James W.,	Farmington
Schmidt, Lorrimer M.,	Strong
Springer, Frank L.,	Farmington

HANCOCK COUNTY

MEMBERS

Babcock, Harold S.,	Castine
Bliss, Raymond V. N.,	Blue Hill
Clarke, Raymond W.,	Ellsworth
Crowe, James H.,	Ellsworth
Gray, Philip L.,	So. Brooksville
Hagopian, Leon G.,	Southwest Harbor
Holt, Hiram Allen,	Winter Harbor
Knowlton, Charles C.,	Ellsworth
Kopfmann, Harry,	Deer Isle
Millstein, Hyman,	Southwest Harbor
Morrison, Charles C., Jr.,	Bar Harbor
Noyes, B. Lake,	Stonington
Parcher, Arthur H.,	Ellsworth
Parcher, George,	Ellsworth
Thegan, Edward,	Bucksport
Wakefield, Ralph W.,	Bar Harbor

HONORARY MEMBER

Higgins, Royal G.,	Bar Harbor

MEMBERS IN MILITARY SERVICE

Cameron, Dwight,	Northeast Harbor
Coffin, Ernest L.,	Northeast Harbor
Coffin, Raymond B.,	Southwest Harbor
Coffin, Silas A.,	Bar Harbor
Larrabee, Charles F.,	Bar Harbor
Sumner, Charles M.,	West Sullivan
Torrey, Marcus A.,	Ellsworth
Trowbridge, Mason,	Ellsworth
Weymouth, Raymond E.,	Bar Harbor

KENNEBEC COUNTY

MEMBERS

Abbott, Henry W.,	116 Main St., Waterville
Bauman, Clair S.,	177 Main St., Waterville
Bisson, Napoleon,	29 Common St., Waterville
Breard, Joseph A.,	15 Summer St., Waterville
Campbell, George R.,	175 Water St., Augusta
Carter, Frederick R.,	43 Sylvan Rd., So. Portland
Cates, Samuel C.,	East Vassalboro
Cobb, William O.,	Gardiner
Coombs, George A.,	283 Water St., Augusta
Cromwell, Charles D.,	Central Maine Sanatorium, Fairfield
Cyr, Gerald A.,	50 Main St., Waterville
Elkins, Harry,	Augusta State Hospital, Augusta
Farrell, Chalmers G.,	Gardiner
Gingras, Adolphe J.,	99 Water St., Augusta
Goodrich, Blynn O.,	165 Main St., Waterville
Gousse, William L.,	Fairfield
Guite, L. Armand,	27 Main St., Waterville
Harlow, Edwin W.,	177 Main St., Waterville
Herring, Leon D.,	Winthrop
Hill, Frederick T.,	177 Main St., Waterville
Hill, Howard F.,	177 Main St., Waterville
Hirschberger, Celia,	44 Main St., Waterville
Jackson, Elmer H.,	304 Water St., Augusta
Kagan, Samuel H.,	283 Water St., Augusta
Kenney, Clarence J.,	Salina, Kansas
Kobes, Herbert R.,	State House, Augusta
Libby, Ara B.,	295 Water St., Gardiner
Lubell, Moses F.,	50 Roosevelt Ave., Waterville
Marquardt, Matthias,	Augusta State Hospital, Augusta
McCoy, Thomas C.,	90 Main St., Waterville
McKay, Roland L.,	284 Water St., Augusta
McLaughlin, Clarence R.,	345 Water St., Gardiner
McQuillan, A. H.,	177 Main St., Waterville
Merrill, Percy S.,	82 Elm St., Waterville
Michaud, Joseph H. C.,	76 Main St., Waterville
Mitchell, Roscoe L.,	111 Western Ave., Augusta
Moore, Arnold W.,	31 Deering St., Portland
Morrell, Arch H.,	State House, Augusta
Newcomb, Charles H.,	Clinton
O'Connor, William J.,	341 Water St., Augusta
Odiorne, Joseph E.,	Cooper's Mills
Parizo, Harry L.,	2 Silver St., Waterville
Piper, John O.,	177 Main St., Waterville
Poulin, James E.,	177 Main St., Waterville
Priest, Maurice A.,	283 Water St., Augusta
Provost, Helen C.,	48 Green St., Augusta
Reynolds, Ralph L.,	101 Main St., Waterville
Risley, Edward H.,	27 College Ave., Waterville
Small, Harold E.,	31 Grove St., Augusta
Small, Morton M.,	11 School St., Waterville
Sommerfeld, Kurt A.,	Gardiner
Stubbs, Richard H.,	133 State St., Augusta
Tyson, Forrest C.,	Augusta State Hospital, Augusta
Ventimiglia, William A.,	Veterans' Adm., Togus
Wheeler, Fred E.,	65 Temple St., Waterville
Williams, Edmund P.,	Oakland
Young, William J.,	51 Landscape Ave., Yonkers, New York

HONORARY MEMBER

Turner, Oliver W.,	37 Stone St., Augusta

MEMBERS IN MILITARY SERVICE

Almond, Henry,	Gardiner
Bourassa, Harvey J.,	Waterville
Bull, Frank B.,	Gardiner
Cook, Aaron,	Waterville
Fay, Thomas F.,	Augusta
Fisher, Samson,	Oakland
Giddings, Paul D.,	Augusta
Gingras, Napoleon J.,	Augusta
Hardy, Theodore E., Jr.,	Waterville
Hurd, Allan C.,	Gardiner
Irgens, Edwin R.,	Waterville
Lambert, Greenleaf H.,	Winthrop
Lathbury, Vincent T., Jr.,	Augusta
McLaughlin, Ivan E.,	Gardiner
McWethy, Wilson H.,	Augusta
Metzgar, John G.,	Augusta

Murphy, Norman B.,	Augusta
Pomerleau, Ovide F.,	Waterville
Pomerleau, Rodolphe J. F.,	Waterville
Pratt, T. Dennie,	Waterville
Provost, Pierre E.,	Augusta
Reynolds, John F.,	Waterville
Shelton, M. Tieche,	Augusta
Towne, Charles E.,	Waterville
Towne, John G.,	Waterville
Trask, Burton W., Jr.,	Rumford

KNOX COUNTY

MEMBERS

Brown, Freeman F.,	5 Beech St., Rockland
Campbell, Fred G.,	Warren
Carswell, James C., Jr.,	Camden
Fogg, Neil A.,	Rockland
Foss, Alvin W.,	11 Beech St., Rockland
Frohock, Horatio W.,	10 Summer St., Rockland
Green, Archibald F.,	60 Elm St., Camden
Hall, Walter D.,	407 Main St., Rockland
Jameson, C. Harold,	465 Main St., Rockland
Keller, Benjamin H.,	407 Main St., Thomaston
Leach, Charles H.,	Pownal
Miller, Herbert L.,	Camden
Millington, Paul A.,	Camden
North, Charles D.,	38 Union St., Rockland
Polisner, Saul R.,	13 Mountain St., Camden
Popplestone, Charles B.,	465 Main St., Rockland
Shields, Victor H.,	North Haven
Tweedie, Hedley V.,	407 Main St., Rockland
Watson, Charles J.,	5 Gay St., Thomaston
Weisman, Herman J.,	76 Limerock St., Rockland

HONORARY MEMBER

Coombs, George H.,	Waldoboro

MEMBERS IN MILITARY SERVICE

Apollonio, Howard L.,	Camden
Brown, Freeman F., Jr.,	Rockland
Dennison, Frederick C.,	Thomaston
Jones, Paul A.,	Union
Kazutow, John,	Bangor
Lawry, Oram R., Jr.,	Rockland
Soule, Gilmore W.,	Rockland
Tounge, Harry G.,	Camden
Wasgatt, Wesley N.,	Rockland

LINCOLN-SAGADAHOC COUNTY

MEMBERS

Barrows, H. C.,	Boothbay Harbor
Belknap, Robert W.,	Damariscotta
Bousfield, Cyril E.,	Woolwich
Day, DeForest S.,	Wiscasset
Doble, Miriam,	Bath
Fuller, Edwin M.,	119 Front St., Bath
Fuller, Edwin M., Jr.,	108 Front St., Bath
Grant, Hugh,	Bath
Gregory, Philip O.,	Boothbay Harbor
Hamilton, Virginia C.,	900 Washington St., Bath
Kershner, Warren E.,	119 Front St., Bath
Laughlin, James W.,	Newcastle
Mills, Nathaniel,	Bath
Morin, Harry F.,	72 Front St., Bath
Parsons, Neil L.,	Damariscotta
Pratt, Edwin F.,	7 Main St., Richmond
Purinton, William A.,	52 Front St., Bath
Smith, Joseph I.,	73½ Front St., Bath
Sommers, Robert,	Richmond
Stetson, Rufus E.,	Damariscotta
Turner, Rodney D.,	East Boothbay
Winchenbach, Francis A.,	Bath

HONORARY MEMBERS

Gregory, George A.,	Boothbay Harbor
Parsons, William H.,	East Milton, Mass.

MEMBERS IN MILITARY SERVICE

Lenfest, Stanley R.,	Waldoboro
Proctor, Thomas E.,	Boothbay Harbor
Smith, Jacob,	Bath
Stott, Ardenne A.,	Bath

OXFORD COUNTY

MEMBERS

Adams, Lester,	Western Maine Sanatorium, Greenwood Mt.
Atwood, Harold F.,	Buckfield
Aucoin, Pierre B.,	77 Rumford Ave., Rumford
Boynton, Willard H.,	Bethel
Burr, Thomas S.,	Municipal Bldg., Rumford
Cohen, Leon,	Fryeburg
Defoe, Garfield G.,	Dixfield
Elsemore, Dexter E.,	Dixfield
Greene, John A.,	96 Congress St., Rumford
Hubbard, Roswell E.,	Waterford
Kay, Edwin,	671 Main St., Lewiston
Leslie, Frank E.,	Norwich, Conn.
MacDougall, James A.,	303 Penobscot St., Rumford
McCarty, Eugene M.,	82 Main Ave., Rumford
McCormack, Roland L.,	Norway
Moody, Harry A.,	150 Congress St., Rumford
Moore, Beryl M.,	Oxford
Nelson, Chelsey W.,	Norway
Noyes, Harriett L.,	114 Congress St., Rumford
Pearson, Henry,	Brownfield
Rauchwerger, Abraham L.,	West Paris
Rowe, William T.,	250 Penobscot St., Rumford
Royal, Albert P.,	82 Main Ave., Rumford
Stanwood, Harold W.,	5 Franklin St., Rumford
Stewart, Delbert M.,	So. Paris
Tibbetts, Raymond R.,	Bethel

HONORARY MEMBER

Sturtevant, James S.,	Dixfield

MEMBERS IN MILITARY SERVICE

Corliss, Leland M.,	West Paris
Courville, Albert L.,	Rumford
Daniels, S. David,	Hebron
Dixon, Walter G.,	Norway
Eastman, Charles W.,	Livermore Falls
Howard, Henry M.,	Rumford
Jackson, Norman M.,	Andover
Lawrence, Homer E.,	Bethel
Oestrich, Alfred,	Mexico
Villa, Joseph A.,	So. Paris
Wilson, Harry M.,	Bethel

PENOBSCOT COUNTY

MEMBERS

Adams, Asa C.,	Main St., Orono
Ames, Forrest B.,	489 State St., Bangor
Blaisdell, Carl E.,	47 Broadway, Bangor
Clement, James D.,	77 Essex St., Bangor
Clough, Dexter J., 2nd,	209 State St., Bangor
Craig, D. Allan,	489 State St., Bangor
Deven, Thomas A.,	10245 47th Ave., Corona, L. I., N. Y.
Dunham, Rand A.,	East Millinocket
Emerson, W. Merritt,	131 State St., Bangor
Fellows, Albert W.,	52 Ohio St., Bangor
Ford, Leonard H.,	217 State St., Bangor
Goodrich, Edward P.,	Winterport
Gumprecht, Walter R.,	116 State St., Bangor
Hall, Walter C.,	Orono
Hammond, Walter J.,	State Hospital, Bangor
Hedin, Carl J.,	State Hospital, Bangor
Herlihy, Edward L.,	159 State St., Bangor
Higgins, George I.,	Newport
Horton, George H.,	Hermon
Hunt, Harrison J.,	162 French St., Bangor

Knowlton, Henry C.,	47 Broadway, Bangor
Lezberg, Joseph,	28 Main St., Bangor
Libby, Harold E.,	Lincoln
Lippincott, Leon S.,	489 State St., Bangor
Maddan, Martin C.,	Old Town
Mansfield, Blanche M.,	191 State St., Bangor
Mason, Luther S.,	109 State St., Bangor
McKay, Hugh G.,	Old Town
McNamara, Wesley C.,	Lincoln
McNeil, Harry D.,	58 Hammond St., Bangor
McQuoid, Robert M.,	39 Columbia St., Bangor
Moulton, Manning C.,	150 State St., Bangor
Pearson, John J.,	Old Town
Peters, William C.,	45 State St., Bangor
Purinton, Watson S.,	15 Ohio St., Bangor
Ridlon, Magnus F.,	99 Broadway, Bangor
Robinson, Harrison L.,	136 Hammond St., Bangor
Ruhlin, Carl W.,	205 French St., Bangor
Schriver, Alfred H.,	16 Parkview Ave., Bangor
Scribner, Herbert C.,	259 Union St., Bangor
Silsby, Samuel S.,	11 Ohio St., Bangor
Skinner, Peter S.,	112 Ohio St., Bangor
Skolfield, Ezra B.,	East Corinth
Small, Amos E.,	31 Central St., Bangor
Smith, LeRoy H.,	Winterport
Stebbins, Arthur P.,	205 French St., Bangor
Strout, Arthur C.,	Dexter
Taylor, Cornelius J.,	18 State St., Bangor
Taylor, Herbert L.,	Dexter
Theriault, Louis L.,	Old Town
Thomas, Calvin M.,	142 No. Main St., Brewer
Thompson, Herbert E.,	390 Center St., Bangor
Thompson, John B.,	316 Center St., Bangor
Vickers, Martyn A.,	268 State St., Bangor
Weatherbee, George B.,	Hampden Highlands
Webber, Merlon A.,	Pittsfield
Weisz, Hans,	Howland
Weymouth, Frank D.,	46 No. Main St., Brewer
Whalen, Henry E.,	Dexter
Whitworth, John E.,	49 Hammond St., Bangor
Woodcock, Allan,	35 Second St., Bangor
Wright, LaForest J.,	39 W. Broadway, Bangor
Young, Ernest T.,	Millinocket

HONORARY MEMBERS

Bayard, Clayton H.,	Orono
Lethiecq, J. Albert,	115 Wilson St., Brewer
Sanger, Eugene B.,	111 State St., Bangor

MEMBERS IN MILITARY SERVICE

Butler, Harry,	Bangor
Clough, Herbert T., Jr.,	Bangor
Comeau, Wilfred J.,	Bangor
Cutler, Lawrence M.,	Bangor
Emery, Clarence, Jr.,	Bangor
Feeley, J. Robert,	Bangor
Gregory, I. Francis,	Bangor
Hall, Walter L. H.,	Old Town
Hill, Allison K.,	Bangor
Hinman, Havilah E.,	Orono
Houlihan, John S.,	Bangor
Miragliuolo, Leonard G.,	Bangor
Munce, Richard T.,	Bangor
Osler, Jay K.,	Bangor
Pressey, Harold E.,	Bangor
Shapero, Benjamin L.,	Bangor
Shurman, Hans,	Dexter
Smith, John E.,	Bangor
Todd, Albert C.,	So. Brewer
Witte, Max E., Jr.,	Bangor

PISCATAQUIS COUNTY

MEMBERS

Brown, Maurice O.,	Dover-Foxcroft
Bundy, Harvey C.,	Milo
Carde, Albert M.,	Milo
Dore, Guy E.,	Guilford
MacDougal, Wilbur E.,	Dover-Foxcroft
Marsh, Stanley N.,	Guilford
Pritham, Fred J.,	Greenville Junction
Stanhope, Charles N.,	Dover-Foxcroft
Stuart, Ralph C.,	Guilford
Valentine, John B.,	Dover-Foxcroft

HONORARY MEMBERS

Crosby, Nathaniel H.,	Milo
Merrill, Elmer D.,	Dover-Foxcroft

MEMBERS IN MILITARY SERVICE

Curtis, John B.,	Milo
Marsh, Burton S.,	Greenville Junction
Howard, George C.,	Guilford
Nickerson, Norman H.,	Greenville
Thomas, Ruth B.,	Dover-Foxcroft
Thomas, William B. S.,	Dover-Foxcroft

SOMERSET COUNTY

MEMBERS

Briggs, Paul R.,	Hartland
Caza, Oliver J.,	North Ave., Skowhegan
Doe, Harvey F.,	Lawrence Ave., Fairfield
Earle, Fred E.,	Weeks Mills
Gilbert, Percy E.,	Madison Ave., Madison
Humphreys, Ernest D.,	91 Main St., Pittsfield
Hutchins, Eugene L.,	No. New Portland
Lord, Maurice E.,	220 Water St., Skowhegan
Marston, Henry E.,	No. Anson
Milliken, Walter S.,	35 Maple St., Madison
Norris, Lester F.,	Maple St., Madison
Philbrick, Maurice S.,	292 Water St., Skowhegan
Reed, Howard L.,	Skowhegan
Stinchfield, Walter S.,	Court St., Skowhegan
Walters, Wilson H.,	16 Summit St., Fairfield
Young, George E.,	Water St., Skowhegan

HONORARY MEMBERS

Ellingwood, Louis N.,	Athens
Moulton, Charles A.,	Hartland

MEMBERS IN MILITARY SERVICE

Ball, Franklin P.,	Bingham
Brann, Henry A.,	Madison
Bernard, Albert J.,	Skowhegan
Laney, Richard P.,	Skowhegan
Stinchfield, Allan J.,	Skowhegan
Sullivan, George E.,	Bingham

WALDO COUNTY

MEMBERS

Read, Seth H.,	Belfast
Small, Foster C.,	169 High St., Belfast
Stevens, Carl H.,	1 Court St., Belfast
Tapley, Eugene D.,	17 High St., Belfast
Torrey, Raymond L.,	W. Main St., Searsport

HONORARY MEMBER

Stevens, Eugene L.,	38 Church St., Belfast

MEMBERS IN MILITARY SERVICE

Caswell, John A.,	Belfast
Jones, Richard P.,	Belfast
Nesbitt, Lester R.,	Bucksport

WASHINGTON COUNTY

MEMBERS

Armstrong, Charles M.,	Robbinston
Bates, James C.,	Eastport
Bennett, DaCosta F.,	Lubec
Brownrigg, Leslie W.,	St. Stephen, N. B.
Buker, Richard S.,	Eastport

Bunker, Willard H.,	Calais
Crane, James W.,	Woodland
Dyas, Alexander D.,	St. Stephen, N. B.
Everett, Herbert S.,	St. Stephen, N. B.
Gilbert, Walter J.,	Calais
Hanson, John F.,	Machias
Jacob, Donald R.,	Princeton
Knapp, Allen H.,	Calais
Larson, Oscar F.,	Machias
Miner, Walter N.	Calais
Mundie, Perley J.,	Calais
Thomas, E. O.,	St. Stephen, N. B.
Webber, Samuel R.,	Calais
Young, John,	Jonesport

HONORARY MEMBERS

Hunter, Sarah L.,	Machias
White, Ernest A.,	Columbia Falls

MEMBERS IN MILITARY SERVICE

Cobb, Norman E.,	Calais
Metcalf, John,	Lubec

YORK COUNTY

MEMBERS

Allen, Pliny A.,	New Orleans, La.
Bacon, Melvin,	Sanford
Baker, William H.,	West Buxton
Belmont, Ralph S.,	207 Main St., Sanford
Corbett, William F.,	229 Main St., Sanford
Davis, Ansel S.,	Springvale
Dennett, Carl G.,	Saco
Dolloff, David E.,	13 Crescent St., Biddeford
Elliott, William T.,	Berwick
Head, Owen B.,	6 Washington St., Sanford
Hill, Paul S.	Saco
Jones, Arthur L.,	Old Orchard
Kelly, William H.,	190 Main St., Sanford
Kinghorn, Charles W.,	Kittery
LaRochelle, Joseph R.,	42 Bacon St., Biddeford
Lengyel, Charles,	Biddeford
Lord, Frederick C.,	260 Main St., Biddeford
Love, George R.,	Saco
Macdonald, James H.,	Kennebunk
Mazzacane, Walter D.,	Old Orchard
Morse, Waldron L.,	Springvale
Moulton, Marion K.,	West Newfield
Nemon, Leon,	243 State St., Portland
Perrault, Oscar W.,	30 South St., Biddeford
Prescott, Harry L.,	Kennebunkport
Ross, H. Danforth,	28 Winter St., Sanford
Small, Fitz E.,	260 Main St., Biddeford
Smith, Gerald R.,	Ogunquit
Stickney, Laura B.,	Saco
Taylor, Paul,	Kittery
Webber, L. Dean,	Kittery
Wiley, Arthur G.,	Bar Mills
Xaphes, Chrysaphes J.,	107 Main St., Biddeford

HONORARY MEMBERS

Gordon, Joseph W.,	Ogunquit
Lightle, William E.,	No. Berwick
Shapleigh, Edward E.,	Kittery
Smith, William W.,	Ogunquit
Stimpson, Arthur J.,	Kennebunk

MEMBERS IN MILITARY SERVICE

Cobb, Stephen A.,	Sanford
Cuneo, Kenneth J.,	Kennebunk
Downing, Jere R.,	Kennebunk
Gould, George I.,	Auburn
Hill, Paul S., Jr.,	Saco
Holland, Edward W.,	Sanford
Kendall, Clarence F.,	Flushing, N. Y.
Mahaney, William F.,	Saco
Murphy, John J.,	Wells Beach
Myer, John C.,	No. Berwick
O'Sullivan, William B.,	Biddeford
Richards, Carl E.,	Alfred
Roussin, William T.,	Biddeford
Tower, Elmer M.,	Ogunquit
Vachon, Robert D.,	Sanford

The Use of Prostigmine in Arrested Poliomyelitis
Continued from page 95

Conclusion and Summary

The reporting of this one case and the relating of subjective manifestations only leaves much to be desired. Prostigmine Bromide seemed to very definitely benefit this victim of Poliomyelitis in making her stronger and more capable of performing her daily duties and the leading of a more useful life. It is hoped that this may stimulate others in the use of Prostigmine Bromide on a larger series of cases and under conditions where objective information may be obtainable.

Editorial—Continued from page 96

hesitant to interfere in the making of decisions as to the assignments or transfer of men in the armed forces. The decisions as to how military personnel are to be utilized must rest with those who carry the responsibility for the ultimate results. This statement is made because many a medical officer has written to the headquarters of the American Medical Association actually demanding that the Association exert its influence to determine the decisions, not only of those responsible for the medical departments of the armed forces, but even of the Secretaries of War and Navy, of the Committees on Military Affairs of the legislative bodies and even of the President. The Board of Trustees and the officers of the Association have felt keenly, nevertheless, the responsibility that rests on them to present to those in authority the facts that should be given serious consideration in the making of decisions concerning medical personnel.

"Unfortunately, steps have not yet been taken by the Selective Service System for a continuing supply of physicians for the future. The medical schools are confronted at this moment with an insufficient number of men to fill their freshman classes in the years immediately to come. The Committee on Military Affairs of the Senate, having given serious and extended hearings to the Ellender bill, has failed to issue a statement of its reaction to that proposal. The time may yet come when those with the authority and the responsibility will have to answer to the people of the United States for a critical situation in the supply of medical service."

Legislation of Interest to M. D.'s, Enacted 1945
Maine Legislature—Continued from page 100

NOT PASSED

The following bills failed to pass:

16. L. D. 49. An act relating to treatment by chiropractors of employees under the Workmen's Compensation Act. Its effect was to include "chiropractic" along with "medical, surgical, and hospital services, nursing, medicine," etc., to which the injured employee is entitled under the law. In short, to recognize chiropractors before the Industrial Accident Commission. In some cases heretofore, the IAC, when convinced that the employee wanted a chiropractor and that the chiropractor's services would be helpful, has authorized the payment. This would legalize that practice. After a stormy career which lasted nearly to the end of the legislative session, this bill was defeated.

17. L. D. 468. An act relating to prenatal examinations. Made mandatory serological test for syphilis during pregnancy. Present law requires patient's consent. Reported favorably by Committee on Public Health. But killed in the House by Representative James B. Perkins of Boothbay Harbor, a member of the powerful Judiciary Committee and presently President of the Maine State Bar Association. Ground: unwarranted if not unconstitutional invasion of the citizen's privacy.

18. L. D. 471. An act relating to public health. Compulsory vaccination. Defeated on the same ground: unwarranted if not unconstitutional interference with private right.

19. L. D. 473. An act amending the control of venereal diseases law. Designed to strengthen control of venereal disease still further. Required report whenever the patient "discontinued treatment while he or she is capable of transmitting the disease to others." Imposed quarantine on a contact case which refused examination and treatment. Killed on the same ground: unwarranted interference with privacy. Possibly unconstitutional, it was argued.

The 15 bills above mentioned which were enacted will be published in the session laws available mid summer. Meanwhile, I can answer any questions which the doctors might have regarding these bills.

Notices—Continued from page 99

Maine General Hospital Medical Grand Rounds

All interested physicians are invited to attend *Medical Grand Rounds* at the *Maine General Hospital* which are now held at *5.15* each *Thursday afternoon* in the *X-ray Department.*

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Rockland, Rumford, Sanford, Waterville, Wilton, Millinocket, Old Town, Portland, Presque Isle, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.

Doctors Look Ahead

"Doctors Look Ahead," a series of dramatized episodes devoted to medical progress and research at home and abroad, is presented by the American Medical Association and the National Broadcasting Company each Saturday at 4.00 P. M., Eastern War Time, unless otherwise announced in local newspapers.

Topics in the series, which began January 6 and will continue through June 30, will be announced weekly in *The Journal of the American Medical Association.*

The broadcast is under the supervision of the American Medical Association's Bureau of Health Education, whose director, Dr. W. W. Bauer, will summarize each program except when other speakers are announced.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Joseph E. Porter, M. D.*

Waterville: *Sisters Hospital*
1st and 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd and 4th Thursdays, 10.00 A. M.
Director, *A. H. McQuillan, M. D.*

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, July, 1945 No. 7

Traumatic Rupture of the Spleen

L. Armand Guite, M. D., Waterville, Maine

Traumatic rupture of the normal spleen is a condition which is seen with increased frequency. In spite of its protected position, deep in the body, the spleen is easily damaged. Cases have been reported in which the trauma was so trivial that the patient does not even remember how it happened. The probability is that in the post-war period more cases will be seen because of two factors:

1. Increase in transportation — particularly military vehicles such as jeeps.

2. Malarial spleens in returning veterans. If the normal spleen is easily ruptured, it goes without saying that the malarial spleen, which has been weakened by disease, can be damaged very readily.

According to Bailey and Schreiber, "The spleen is involved in 47.6% of all subcutaneous injuries in the abdomen either isolated or complicated with other injuries. Therefore, injury to the spleen outranks trauma to the liver or kidney."[1] They point out further that the diagnosis is easily missed, perhaps because of several features:

1. Absence of visible signs of injury to abdominal wall.

2. Misleading histories.

3. Shock which is present is thought to result from associated injuries to the head, chest, or extremities.

The commonest cause of hemoperitoneum is ruptured spleen, and should be first thought of in traumatic injury of the addomen. It is sufficient to point out that cases of delayed rupture of the spleen do exist.

Commonly the cases of ruptured spleens are divided into two groups — capsular and subcapsular; capsular rupture accounting for immediate bleeding, and sub-capsular rupture accounting for delayed rupture and subsequent bleeding.

It should be pointed out that the location of the injury is of great significance. Lacerations of the periphery of the spleen are not as serious as lacerations of the hilus of the spleen. Any injury near the splenic vessels is apt to cause immediate and severe bleeding.

As soon as the diagnosis of splenic injury is made, the patient should be subjected to an operation. The extent of splenic injury is impossible to evaluate, and the safest course is in an exploratory operation.

The mortality of the average splenectomy is 10%, whereas the mortality without operation,

according to Thorek, is 77% to 100%. This author quotes a case in which he was called in consultation for a child who was injured by a taxicab. Injury of the spleen was diagnosed. Conservative measures were decided upon in view of the apparently encouraging condition of the patient. A few days later he was notified by the attending physician that the patient had died from what appeared to be a fulminating hemorrhage. Post mortem examination disclosed a ruptured spleen with secondary hemorrhage. It, undoubtedly, was responsible for the death of the patient.[2]

One is tempted to wait when the patient is apparently improving; but, as these statistics show, the answer is evident. The treatment of shock is a prerequisite to operation; plasma, and particularly whole blood, should be administered as soon as possible.

A recent editorial in *Surgery, Gynecology, and Obstetrics* calls attention to the fact that plasma alone is looked upon as a first aid measure for hemorrhage, but not as a substitute for whole blood. "The 'recovery' from shock that follows plasma infusion affords a false sense of security to the doctor who administers it—particularly if he is not an experienced surgeon. It may encourage him to attempt operative surgery that the patient is not prepared to withstand."[3] The proportion of blood to plasma should be in relative amounts of three to one.

The author wishes to report a recent case of ruptured spleen in which a splenectomy was performed followed by recovery.

Male, aged 12, admitted to the Sisters' Hospital, February 23, 1945, with the following history:

The patient was standing on a piazza with his back against a rail when a cake of solid ice estimated to weigh between 30 to 35 pounds fell off a three-story building and struck him a glancing blow on the chin and the left side of the abdomen. The blow was sufficient to break the rail behind the boy's back, and also the floor of the porch. He was seen within five minutes after injury. The abdomen was board-like, and the patient was groaning with pain. There was deep surgical shock present. His hands were deathly pale and cold, and his pulse was weak and thready. The patient had just recovered consciousness and was rushed to the hospital where he was taken immediately to the operating room and given a solution containing approximately 300 cc. of plasma and 200 cc. of glucose saline solution intravenously. He was also given a twelfth of a grain of morphine, and placed in shock position with hot blankets and hot water bottles. Blood pressure on admission was 96/60.

He was typed immediately, and found to be in group A, Rh positive. The boy reacted fairly well from shock, and was kept up in the operating room for approximately 1½ hours and then sent down stairs to bed. The diagnosis of Splenic injury was suspected immediately. It was quite evident that the patient had had a hemoperitoneum. Abdominal rigidity was generalized and there was diffuse tenderness throughout the abdomen. Examination of the back showed a fairly large ecchymosis of the skin in the left lumbar region. Pulse rate and blood pressure were ordered every hour. The patient spent a fairly restless night, vomiting once. There was no blood in the vomitus. Early the next morning, twelve hours after admission, the patient's blood pressure had gone up to 125/85. He was still having severe pain. 500 cc. of 5% glucose was given intravenously.

A flat plate of the abdomen taken with the portable showed the stomach distended. There was no free air under the diaphragm. Both lung fields were clear. A transverse fracture of the 3rd lumbar vertebrae on the left side was seen. There was no evidence of a diaphragmatic hernia. The red count was 3,120,000, with a Hemoglobin of 76%.

Color index, 1. White blood count was 10,350. Polys., 86%; Lumphs, 12%. There was some anisocytosis.

The patient was seen in consultation with Dr. A. H. McQuillan. The diagnosis of splenic injury was confirmed. Operation was advised if the red blood count showed a progressive decrease.

Abdominal examination at this time was extremely interesting. The abdominal veins were dilated and the abdomen appeared somewhat distended. He had a positive Cullen's sign (bluish discoloration of the umbilicus), indicating a hemoperitoneum. There was tenderness and rigidity throughout the entire abdomen. Rigidity was not confined to any particular location. Because of the stomach dilatation a Levine tube was inserted and Wan-

gensteen suction applied. The urine examination showed no trace of blood. Kidney injury was ruled out. A transfusion of 400 cc. of citrated blood was given by the indirect method.

TABLE I.

February 14:

	Red blood count	*Hb.*
8:00 a. m.	3,120,000	62%
12:00 noon	3,090,000	62%
Transfusion, 400 cc. of citrated blood.		
4:00 p. m.	3,280,000	69%

Repeated blood counts taken during the day (see Table I), showed that the patient was holding his own. The Levine tube drained freely. Blood pressure held up to around 124.

Reexamination of the abdomen later in the afternoon showed that the distention had gone down. Most of the tenderness and rigidity had shifted to the left upper quadrant. In view of the satisfactory progress up to this time we could have been easily tempted to wait, but operation was decided upon. At 9:00 A. M., February 25, approximately 38 hours after admission, the patient was operated upon. Just before the operation began, and while the patient was under ether anesthesia, a transfusion of 500 cc. of citrated blood was started. A long, left, upper paramedian muscle-splitting incision was made. On opening the peritoneum there was a bloody discoloration of the intestines encountered. The stomach and liver showed no evidence of injury. Approximately a pint of blood was found in the pelvic cavity and was removed by suction. Exploration of left upper quadrant showed considerable quantity of blood coming from that location. The intestines were walled off carefully, and the spleen mobilized outside of the abdominal cavity being very careful not to injure it further. Exploration showed several deep lacerations involving the hilus of the spleen. The splenic vessels were located and divided between a double row of clamps and ligated with three separate chrome No. 2 sutures, being careful not to involve the tip of the pancreas, and the spleen was removed. The abdomen was closed in layers without drainage. The patient withstood the operation satisfactorily. He required 3½ grains of caffeine sodium benzoate for stimulation. As soon as the transfusion ended the patient was sent to bed. The post-operative course was stormy. On the night of the operation the patient's temperature shot up to 105°. He became extremely restless and somewhat irrational, but he eventually straightened out and from that point on, outside of occasional gas pains, he made an uneventful recovery, and was discharged from the hospital on the 18th post-operative day.

SUMMARY

A case of splenic injury in a twelve-year-old school boy due to a rather unusual type of accident (falling ice from a roof) is reported. The boy was successfully treated by supportive measures for shock and a splenectomy performed.

Attention is called to the increased frequency of splenic injuries, and to the probability of a further rise in the post-war period due to:

1. Increase in transportation.
2. Malarial spleens in the returning soldiers.

The urgency of an immediate operation as soon as the shock is controlled is stressed.

CONCLUSIONS

1. Splenic injury occurs with increased frequency, and is the commonest cause of hemoperitoneum.
2. Splenectomy is the only rational treatment for splenic injury.

REFERENCES

1. Bailey, H. S., Schreiber, S. L.: Delayed Rupture of the Spleen, *American Journal of Surgery,* 66:4, 1944.
2. Thorek, Max: Operations on the Spleen, Surgical Errors and Safeguards, 12:608-616, 1943.
3. Editorial, Plasma, Surgery, Gynecology and Obstetrics, 80:335, 1945.

Family life in contact with a case of tuberculosis greatly increases risk of the infection spreading, especially in the age group when health is of maximum economic and social importance.—GEORGE H. RAMSAY, M. D., ET AL., *Health News,* October 21, 1940.

The Use of Insulin in Malnutrition Due to Nervous Dyspepsia

Report of a Case

Melvin Bacon, M. D., Sanford, Maine

In the past twenty years, a number of articles have appeared on the use of insulin in the treatment of non-diabetic malnutrition. The largest series of cases in this country has been reported by Blotner[1] who has used it with considerable success in his group of patients. In addition, he found it of great value in those individuals who were thin because of nervous dyspepsia.[2] Because of the striking response with insulin in a case of nervous dyspepsia with regard to amelioration of symptoms and gain in weight it appeared of interest to report this case.

Case History

Mrs. E. P., age 29, was first seen on August 24, 1944, because of loss of weight and appetite, nervousness, weakness and fatigue.

The past and family history are irrelevant. She has been married eight years and her husband and one child, age seven years, are living and well.

Her menses are irregular and infrequent.

Her illness began several years ago following the birth of her son. At that time she weighed 95 to 100 pounds. She could not sleep, was nervous, had loss of appetite and became dizzy and weak. She also had intermittent nausea and vomiting. Some epigastric distress, gas and pain were present. She began to lose weight slowly and steadily, until on September 2, 1944, she weighed 74 pounds and treatment was begun. During the past 6 years she was at no time able to regain any of the weight lost or even arrest it despite the use of various medications, high caloric diet and attendance at several clinics. Her symptoms continued up to the time the present treatment was started.

Physical examination revealed a 29-year-old white, well developed, but poorly nourished female, who looked older than her stated age. Her height was 60 inches and weight was 74 pounds. Her pulse was 72. Aside from her malnutrition and blood pressure of 90/70, the general physical examination was negative.

Laboratory Data

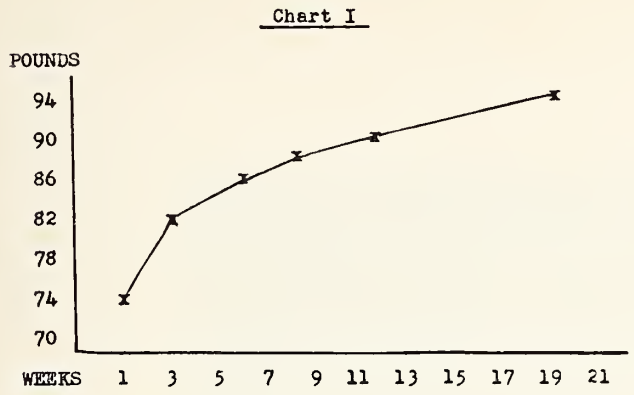
The hemoglobin was 82% and red blood count 4,300,000 while the white blood count was 7,300 and the differential normal. Her urine was negative. The B. M. R. was minus 4%. Blood and urine chlorides were normal. Hinton test was negative. The fasting blood sugar was 81 mg. %. X-rays of the chest showed no pathology. A gastrointestinal series with fluoroscopy were within normal limits except for slight gastroptosis. Cholecystograms were negative. Gastroptosis may be found frequently in undernourished individuals. Blotner[2] found it present in his series of cases.

Diagnosis

A variety of conditions such as tuberculosis, Addison's Disease, peptic ulcer and gall bladder disease were considered. These, however, were ruled out. The final diagnosis appeared to be malnutrition due to neurasthenia.

Treatment

Because of the reports showing the beneficial effects of insulin in non-diabetic malnutrition, it was decided to employ this method of treatment particularly because other methods had failed in this case. Consequently, she was given a high caloric diet and was taught to inject herself with 7 units of insulin, three times daily, ½ hour before meals. She was told about the symptoms of insulin reactions and how to avoid them. Subsequently, she gained about 20 pounds as illustrated in Chart I. The gain in weight was most rapid at the beginning of insulin therapy and then became less marked as the patient's weight approached her normal level.



Gain in weight with insulin therapy.

With the gain in weight her symptoms disappeared. She became less nervous, more active and less fatigued on exertion. Her digestion became normal. In the place of her former symptomatology, a feeling of well being has ensued along with a more youthful and healthy appearance. She had no insulin reactions.

Measurements of various parts of the body were taken at the onset of treatment and after a gain of 20 pounds of weight. These findings are shown in Chart II.

Measurements

	Before	*After*
Waist,	23 inches	25 inches
Hips,	31 inches	33 inches
Bust,	29 inches	32 inches

It has been shown[3] that a gain of weight through the use of insulin was due to an increase in the deposition of fat. It would seem from the above figures that the deposition of fat was uniform. The effect of insulin apparently results in better digestion, better assimilation and increase in weight with a uniform increase in fat distribution.

Conclusion

This paper presents a case of malnutrition due to nervous dyspepsia treated with insulin and a high caloric diet. The patient injected herself with 7 units of insulin, three times daily, one-half hour before meals. This resulted in an amelioration of her symptoms with a gain of 20 pounds in weight and a marked improvement in her general appearance.

References

1. Blotner, H.: Observations on the effect of insulin in thin persons, *J. A. M. A.*, 100:88, 1933.
Late results following the use of insulin in one hundred cases of malnutrition, *New Eng. Jour. Med.*, 218:371, 1938.
2. Blotner, H.: The use of insulin in malnutrition due to nervous dyspepsia, *Rev. Gastroent.*, 6:234-239, 1939.
3. Blotner, H.: The changes produced in fat tissue by the use of insulin in malnutrition, *J. A. M. A.*, 100:1235, 1933.

Most of the tuberculous patients who seek medical aid today have had many reinoculations with many resultant foci of varying degrees of severity. The best that clinicians can do in a short course of treatment in such a chronic disease is to secure a truce between the patient and his bacilli, a truce which may be broken on either side: by the bacilli if their environment becomes congenial for their growth and multiplication; by the patient if he can increase his resistance sufficiently, maintain it at a high level, and thus prevent the bacilli from further activity.

Here is where we are making one of our most abject failures in treating tuberculosis. Both physicians and patients are prone to lose interest; and treatment is often interrupted before healing has been attained. By relaxing measures necessary to complete healing, the patient's defensive powers are allowed to lower, the tissues lose their resistance and new activity starts. Thus are caused the many relapses which plague us and make us almost lose confidence in therapeutic measures. A little longer treatment and a great deal longer extension of the careful life after treatment has been finished, and a full rehabilitation of the patient before he is discharged from observation, and many of the reactivations which we speak of as "breakdowns" would be avoided and many sources of infection would be permanently instead of temporarily eliminated. F. M. Pottenger, M. D., *Amer. Rev. of Tbc.*, Aug., 1944.

Editorial

House of Delegates — 1945

The House of Delegates of the Maine Medical Association met on Sunday, June 24, 1945, at the Augusta House, Augusta, Maine, in place of the regular annual meeting which was canceled in accordance with a ruling from the Office of Defense Transportation.

Twenty-three delegates responded to the Roll Call at the First Meeting of the House which was called to order at 11.00 A. M., by Adam P. Leighton, M. D., of Portland, President-elect. A Nominating Committee consisting of one delegate from each Councilor District was appointed to draw up a Slate of Standing Committee members for 1945-1946, for presentation at the Second Meeting of the House. The report of this committee which was accepted is published elsewhere in this issue of the JOURNAL.

The Council Report for 1944-1945 as presented by E. Eugene Holt, Jr., M. D., Chairman, and accepted by the House, is on file in the Association office.

The Budget for 1945-1946 as recommended by the Council and accepted by the House totals $7,300.00; the same as in 1944-1945. This, as well as Councilor and Committee reports, not published in the June issue of the JOURNAL and presented at this meeting of the House, will appear in the proceedings of the House of Delegates to be published at a later date.

R. V. N. Bliss, M. D., of Blue Hill, President, presided at the General Session following the luncheon. His Presidential Address will appear in a later issue of the JOURNAL.

Speakers at this meeting were: John J. Moorhead, M. D., Professor of Surgery, New York Medical School, and Albert S. Crawford, M. D., Neurological Surgeon, Henry Ford Hospital, Detroit, Michigan. Doctor Moorhead, who was at Pearl Harbor at the time of the attack by the Japanese, spoke of the work there and of modern drugs and surgical equipment. His talk was illustrated by lantern slides. Doctor Crawford gave an illustrated lecture on "Nerve Compression Syndrome of Lumbar Nerves, Modern Concepts and Surgical Treatment."

John O. Piper, M. D., of Waterville, was elected President-elect of the Association, in accordance with a vote of the House of Delegates that the election of the President-elect take place at the general session.

Waldron L. Morse, M. D., of Springvale, was elected Councilor for the First District, and Ralph A. Goodwin, M. D., of Auburn, Councilor for the Second District, at the Second Meeting of the House which convened immediately following the general session. Roland L. McKay, M. D., of Augusta, was elected Councilor for the Fourth District, for a two-year term to fulfill the unexpired term of Doctor Piper.

The Council of the Association held two meetings; the first at 10.00 A. M., at which time it was voted, "That the President be delegated to attend meetings of the New England Council, and if unable to attend that he be granted power to appoint some one else to attend, preferably a member of the Council." At the second meeting, which was held to organize the Council for the ensuing year, Forrest B. Ames, M. D., of Bangor, was elected Chairman.

ADAM P. LEIGHTON, M. D.

President Maine Medical Association

1945 - 1946

Adams Phillips Leighton, M. D.

Adam P. Leighton, M. D., of Portland, incoming President of the Maine Medical Association is well known to the members.

He was born in Portland, Maine, January 23, 1887. He attended the public schools in Portland, Holbrook School in Ossining, New York, and Phillips Exeter Academy, and was graduated from Bowdoin Medical School in 1910. After serving a one-year interneship at the Maine General Hospital, Portland, he studied abroad at the Rotunda Hospital, Dublin, Ireland, and in the Schauta Klinik, Vienna, Austria.

Doctor Leighton opened a private practice in Portland in 1912 and in 1913 founded a private maternity hospital on Emery Street, which he successfully conducted until 1944 when he closed it because of wartime conditions.

During World War I, he served as a medical officer in the U. S. Navy and at its conclusion held the rank of lieutenant commander in the naval reserves.

He is a past president of the Portland Medical Club, the Aegis Medical Club, and the Cumberland County Medical Society. He is a Fellow of the American Medical Association, Fellow of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, a Diplomate of the American Board of Obstetrics and Gynecology, and a member of the Cumberland County and State Medical Associations.

For thirty years he has been a member of the Maine State Board of Registration of Medicine, having served as a secretary and chairman of this organization. On February 15, 1944, Doctor Leighton was elected President of the Federation of State Medical Boards of the United States at the annual convention held in Chicago.

He has been a member of the Kiwanis Club, American Legion, and many Masonic branches, including Kora Temple, Mystic Shrine at Lewiston, of which he is a Past Potentate.

The Association is fortunate in these trying times in having as its President a man so well qualified.

The President's Page

To the Members of the Maine Medical Associaton:

According to the edict of the O. P. A., we were unable to hold our Annual Meeting this year. It was too bad, but we willingly bow to Government orders and the exigencies of War. An excellent program had been arranged. Medical celebrities were to have been our guests, and the scientific session would have been most interesting and valuable. We shall immediately start plans for next June, and if a meeting may be held, I promise you that it will be worthwhile and replete with entertainment.

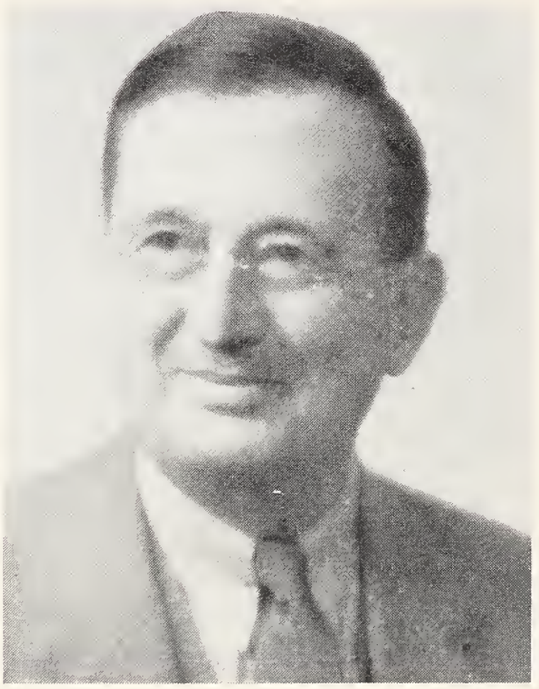
The House of Delegates met in Augusta on June twenty-fourth at the Augusta House. Much business was transacted. The President-Elect and new officers were chosen. Considering the spirit shown and the assured coöperation of each and every member, there is every reason to be certain of a most successful year. The War is still in progress, and it means the continuation of our many problems. With the spectre of Socialized Medicine before us and the diminution in the number of medical practitioners, plus increased demands for medical care, the situation offers a distinct challenge to Maine Medicine.

Those who attended the meeting last Sunday, certainly were amply repaid, for the two guest speakers presented most remarkable and interesting subjects. Would that each and every member of the Association might have heard the timely talk given by Dr. John J. Moorhead of New York City. Dr. Moorhead who is the author of a recently published textbook on "Traumatic Surgery," was in Pearl Harbor at the time of the Japanese attack. He explained the technique of War Surgery and the skillful treatment of these casualties. His talk was beautifully illustrated by stereopticon. For an hour and a half, we sat spellbound, as we listened to the description of this epoch-making catastrophe. Dr. Albert S. Crawford of Detroit, a nationally known neurological surgeon, too, enhanced the enjoyment of the occasion with his presentation of spinal nerve root surgery.

I hope to meet you all, during the year, at your County meetings. Let's maintain the old time spirit and keep the membership alive and active. It is my duty and your duty. Let us give thought and consideration to those of our confreres who are away at the Front, with their backs turned, fighting for you and me, and in our deliberations be guided by a thought as to what they would desire us to do during their absence. They are coming back before very long to again take up their individual practices. Let us not falter, but continue to carry on faithfully and conscientiously to make the future safer for them.

Adam P. Leighton, M. D.,
President, Maine Medical Association.

The President-elect



John O. Piper, M. D.
Waterville

John O. Piper, M. D., of Waterville, was elected President-elect of the Maine Medical Association at a meeting of State Association Officers and County Society delegates held Sunday, June 24, 1945, at Augusta, Maine.

Doctor Piper was born at Bingham, Maine, July 14, 1881. He was graduated from Bates College in 1903, and received his medical degree from McGill University in 1910. He later took courses in Internal Medicine at the University of Pennsylvania and the New York Post-Graduate School.

He has practiced in Waterville since 1924. Previous to that he was located, from the time of his graduation, in Solon, Maine.

During World War I, he served as a 1st Lieutenant in the Medical Corps of the U. S. Army.

Doctor Piper is a Fellow of the American College of Physicians, a Fellow of the American Medical Association, a Diplomate of the American Board of Internal Medicine, and a member of the New England Heart Association, the Maine Medical Association, and the Kennebec County Medical Society. He is keenly interested in all things pertaining to his profession and has served as Councilor for the Fourth District for the past four years.

Council Chairman and Councilors Elected

at the

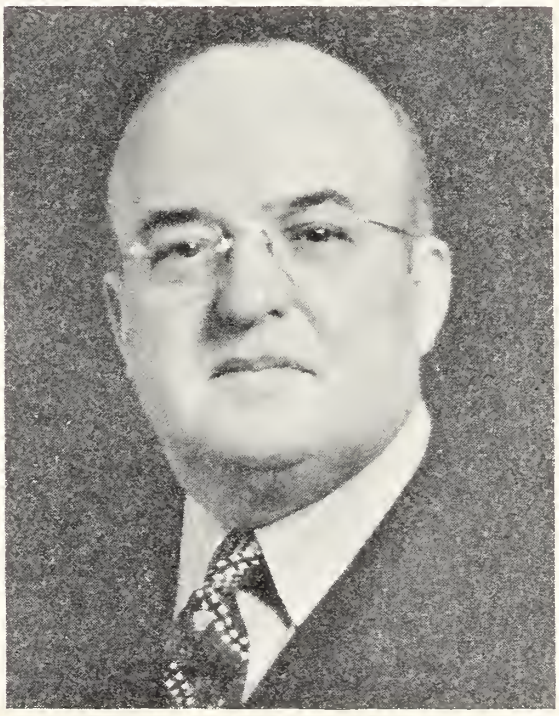
HOUSE OF DELEGATES MEETING

JUNE 24, 1945 *AUGUSTA, MAINE*

Forrest B. Ames, M. D.
Bangor
Chairman, 1945-1946

Waldron L. Morse, M. D.
Springvale
Councilor, First District, 1948

Ralph A. Goodwin, M. D.
Auburn
Councilor, Second District, 1948



Roland L. McKay, M. D.
Augusta
Councilor, Fourth District, 1947

Nominating Committee Report

The report of the Nominating Committee as presented and accepted at the Second Meeting of the House of Delegates of the Maine Medical Association at Augusta, Maine, June 24, 1945.

Nominating Committee

First District:	Francis J. Welch, M. D., Portland, Chairman
Second District:	Garfield G. Defoe, M. D., Dixfield
Third District:	C. Harold Jameson, M. D., Rockland
Fourth District:	Clarence R. McLaughlin, M. D., Gardiner
Fifth District:	James H. Crowe, M. D., Ellsworth
Sixth District:	Martyn A. Vickers, M. D., Bangor

Standing Committees

Scientific Committee

Ralf S. Martin, M. D., Portland, Chairman (One Year)
Dexter E. Elsemore, M. D., Dixfield (Two Years)
Francis A. Winchenbach, M. D., Bath (Three Years)
Martyn A. Vickers, M. D., Bangor (Four Years)
The Secretary, ex-officio

Committee on Medical Education and Hospitals

D. Allan Craig, M. D., Bangor, Chairman (One Year)
Stephen S. Brown, M. D., Portland (Two Years)
David E. Dolloff, M. D., Biddeford (Three Years)

Medical Advisory Committee

Allan Woodcock, M. D., Bangor, Chairman
Carl M. Robinson, M. D., Portland
Frank A. Smith, M. D., Westbrook
Philip L. Gray, M. D., South Brooksville
C. Harold Jameson, M. D., Rockland
Frank H. Jackson, M. D., Houlton
Forrest B. Ames, M. D., Bangor
The Secretary, ex-officio

Legislative Committee

The President, ex-officio
The President-elect, ex-officio
Frederick R. Carter, M. D., Portland, Chairman

Public Relations Committee

Frederick T. Hill, M. D., Waterville, Chairman
Roland L. McKay, M. D., Augusta
Henry C. Knowlton, M. D., Bangor
Henry P. Johnson, M. D., Portland
Joseph A. Donovan, M. D., Houlton

Cancer Committee

Julius Gottlieb, M. D., Lewiston, Chairman (Four Years)
Arthur H. McQuillan, M. D., Waterville (Three Years)
William Holt, M. D., Portland (Two Years)
Magnus F. Ridlon, M. D., Bangor (Four Years)
Forrest B. Ames, M. D., Bangor (Five Years)
Joseph E. Porter, M. D., Portland (Six Years)

Committee on Social Hygiene

Oscar R. Johnson, M. D., Portland, Chairman (One Year)
Storer W. Boone, M. D., Presque Isle (Two Years)
Carl E. Blaisdell, M. D., Bangor (Three Years)

Publicity Committee

Frederick R. Carter, M. D., Portland, Chairman
President, Adam P. Leighton, M. D., Portland
President-elect, John O. Piper, M. D., Waterville

Special Committees

As appointed by the President, Adam P. Leighton, M. D., Portland, in accordance with the By-Laws, Chapter V, Section I.

Committee on Graduate Education

Frederick T. Hill, M. D., Waterville, Chairman
Julius Gottlieb, M. D., Lewiston
Frank H. Jackson, M. D., Houlton
LeRoy H. Smith, M. D., Winterport
James Carswell, M. D., Camden
William Holt, M. D., Portland
Magnus F. Ridlon, M. D., Bangor

Tuberculosis Committee

Francis J. Welch, M. D., Portland, Chairman
Walter R. Gumprecht, M. D., Bangor
Loren F. Carter, M. D., Presque Isle
Charles D. Cromwell, M. D., Fairfield
Lester A. Adams, M. D., Hebron
George E. Young, M. D., Skowhegan
Rufus E. Stetson, M. D., Damariscotta
Herbert S. Everett, M. D., St. Stephen, N. B.

Committee on Maternal and Child Welfare

Albert W. Fellows, M. D., Bangor, Chairman
Clair S. Bauman, M. D., Waterville
Leroy C. Gross, M. D., Auburn
Alice A. S. Whittier, M. D., Portland
Virginia C Hamilton, M. D., Bath
Theodore M. Stevens, M. D., Portland
Thomas A. Foster, M. D., Portland

Committee to Survey Hospital and Medical Care

S. Judd Beach, M. D., Portland, Chairman
Franklin A. Ferguson, M. D., Portland, Secretary
Gerald R. Smith, M. D., Ogunquit (First District)
Currier C. Weymouth, M. D., Farmington (Second District)
Warren E. Kershner, M. D., Bath (Third District)
Edward H. Risley, M. D., Waterville (Fourth District)
Willard H. Bunker, M. D., Calais (Fifth District)
Clyde I. Swett, M. D., Island Falls (Sixth District)
Roscoe L. Mitchell, M. D., Augusta (Department of Health and Welfare)

Committee to Investigate Collection Agencies

Adam P. Leighton, M. D., Portland

Committee on Industrial Health

Harold W. Stanwood, M. D., Rumford, Chairman
Isaac M. Webber, M. D., Portland
Edwin M. Fuller, M. D., Bath
Allan Woodcock, M. D., Bangor
Roscoe L. Mitchell, M. D., Augusta
John G. Towne, M. D., Watervile

Committee on Conservation of Vision

E. Eugene Holt, M. D., Portland, Chairman
Howard F. Hill, M. D., Waterville
S. Judd Beach, M. D., Portland
Walter J. Gilbert, M. D., Calais
William R. McAdams, M. D., Portland

Amy W. Pinkham Fund Committee

Thomas A. Foster, M. D., Portland, Chairman
Virginia C. Hamilton, M. D., Bath
Albert M. Carde, M. D., Milo
Clair S. Bauman, M. D., Waterville
P. L. B. Ebbett, M. D., Houlton
John F. Hanson, M. D., Machias
Carl H. Stevens, M. D., Belfast

Committee to Formulate Plans for Re-opening of Medical School of Maine

Eugene E. O'Donnell, M. D., Portland, Chairman
Allan Woodcock, M. D., Bangor
Francis J. Welch, M. D., Portland
Frederick T. Hill, M. D., Waterville
Carl M. Robinson, M. D., Portland
Adam P. Leighton, M. D., Portland

COUNTY SOCIETIES

Androscoggin
President, Romeo A. Beliveau, M. D., Lewiston
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Fort Fairfield

Cumberland
President, Henry P. Johnson, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Francis A. Winchenbach, M. D., Bath
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Knox

A meeting of the Knox County Medical Society was held Tuesday, June 12th, 1945, at Rockland, Maine.

Samuel Proger, M. D., of the Pratt Diagnostic Clinic, Boston, conducted a clinic at the Knox County General Hospital in the afternoon.

Dinner at the Copper Kettle was followed by a very informative paper on *Hypertension,* presented by Doctor Proger.

PAUL A. MILLINGTON, M. D.,
Secretary.

Oxford

A regular meeting of the Oxford County Medical Society was held at Bethel Inn, Bethel, Maine, Wednesday, June 13, 1945.

Vice President, Harold W. Stanwood, M. D., called the meeting to order.

Minutes of the preceding meeting were read and accepted. Communications read and filed.

Josef Hubert Giesen, M. D., U. S. Naval Hospital, Parris Island, South Carolina, and Sabine Holin, M. D., of Hebron, were elected to membership.

We were pleased to have the following guests present: Frederick R. Carter, M. D., of Portland, Secretary-Treasurer of the Maine Medical Association, and George H. Coombs, M. D., of Waldoboro, a former member of the Maine Board of Health. Doctor Carter spoke in regard to the special meeting of the House of Delegates to be held in Augusta, June 24th, and said that Officers of County Societies had been requested to ascertain from their membership their feeling relative to new officers being elected or present officers retained.

It was voted to send the Delegates of this Society uninstructed.

In the dining room a fine dinner was served after which W. Eldridge Smith, of the Commercial Casualty Insurance Company, gave an outline of *Group Health Insurance.* The Society voted to go on record as favoring this plan as described by Mr. Smith.

Joseph E. Porter, M. D., of the Department of Pathology, Maine General Hospital, Portland, Maine, gave a very interesting and instructive lecture with lantern slides on *Investigation of Sudden Death.*

There were forty-nine members and guests present.

J. S. STURTEVANT, M. D.,
Secretary.

Piscataquis

A dinner meeting of the Piscataquis County Medical Society, to which the ladies were invited, was held

on May 18, 1945, at Blethen House, Dover-Foxcroft, Maine. Following the dinner the meeting was held in an adjoining room and was called to order by the President, Doctor Carde.

Minutes of the previous meeting were read and approved. Under new business it was voted to endorse the group health and accident contract as submitted by the Commercial Casualty Insurance Company, whose general agent is H. F. Scott, of Bangor, Maine.

It was voted to hold a mid-summer meeting at Moosehead Lake, and that the Penobscot, Somerset and Kennebec County Medical Societies be invited to attend. Arrangements for this meeting were left with the officers and Doctor Pritham.

It was voted to hold the annual meeting at the office of Stanley Marsh, M. D., in Guilford.

R. V. N. Bliss, M. D., President of the Maine Medical Association, was the guest speaker of the evening. Following a few timely remarks he gave a fine talk on the life and accomplishments of William Stuart Halstead.

There were twenty-two members and guests present.

H. C. Bundy, M. D.,
Secretary.

New Members

Oxford

Josef H. Giesen, M. D., Parris Island, So. Carolina
Sabine Holin, M. D., Hebron, Maine

Notices

Medico-Legal Conference and Seminar, October 1-6, 1945, Boston, Massachusetts

The Department of Legal Medicine of the medical schools of Harvard, Tufts, and Boston University in association with the Massachusetts Medico-Legal Society will present a six-day program of lectures, conferences, and demonstrations having to do with the investigation of deaths in the interests of public safety. Attendance during five of the six days of the course will be limited to fifteen persons who have registered in advance. On one day (October 3) the program will be open to any physician, lawyer, police official, or senior medical student who may care to attend.

Further information may be obtained from the secretary of the Massachusetts Medico-Legal Society, 25 Shattuck Street, Boston.

Hospital Staff Meetings Open to the Profession

Augusta General Hospital, Augusta .... 1st Wednesday
Cary Memorial, Caribou ..... 1st Wednesday
Central Maine General, Lewiston ..... 1st Monday
Eastern Maine General, Bangor ..... 2nd Tuesday
Goodall Memorial, Sanford ..... 2nd Monday
Knox County, Rockland ..... 1st Monday
Maine General, Portland ..... 2nd Friday
Mercy Hospital, Portland ..... 3rd Thursday
Miles Memorial, Damariscotta ..... 1st Thursday
Presque Isle General, Presque Isle .....
1st and 3rd Tuesdays
Rumford Community, Rumford ..... 4th Wednesday
Sisters Hospital, Waterville ..... 2nd Tuesday
St. Mary's General, Lewiston ..... 2nd Monday
Thayer, Waterville ..... Every Thursday
Waldo County, Belfast ..... 2nd Friday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Joseph E. Porter, M. D.*

Waterville: *Sisters Hospital*
1st and 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd and 4th Thursdays, 10.00 A. M.
Director, *A. H. McQuillan, M. D.*

Treasurer's Report

To the Officers and Members of the Maine Medical Association:

The books of the Association and JOURNAL were closed and audited as of May 31, 1945, by Jordan and Jordan, Accountants and Auditors, Portland, Maine, who have "found the same complete and correct in all details of record," and who have submitted the following statements "properly drawn up to show the true financial position of the Association, May 31, 1945, and the income and expense for the year under review."

FREDERICK R. CARTER, M. D.,
Treasurer.

BALANCE SHEET, MAY 31, 1945

ASSETS

Cash in Banks		$12,720.89
Accounts Receivable:—		
Dues	$ 48.00	
Advertising	499.36	
Sundry	23.82	
		571.18
Securities		9,765.00
Furnishings and Equipment		1,092.59
Impounded Cash		1,099.53
Trust Fund Investments		2,453.31
Total Assets		$27,702.50

LIABILITIES, CAPITAL AND TRUST FUNDS

Withholding Taxes		$ 74.10
Capital Account:—		
Balance June 1, 1944	$24,099.01	
Add:—		
Net Gain on Securities Called	60.00	
Revenue in Excess of Expense (One Year)	1,016.08	
		25,175.09
Trust Funds		2,453.31
Total Liabilities, Capital and Trust Funds		$27,702.50

TRUST INVESTMENTS AND FUNDS

MAY 31, 1945

Prince A. Morrow Trust:—		
12 shares American Agricultural Chemical Co. (Cost)	$348.00	
Canal National Bank — Savings No. 3905	843.72	
Fidelity Trust Co. — Savings No. 54236, Impounded	24.26	
		$1,215.98
Thayer Library Trust:—		
Canal National Bank — Savings No. 3903	$1,102.49	
Fidelity Trust Co. — Savings No. 54631, Impounded	134.84	
		1,237.33
Total Trust Fund Investments		$2,453.31

Prince A. Morrow Fund:—		
Principal	$568.52	
Income	647.46	
		$1,215.98
Thayer Library Fund:—		
Principal	$1,229.72	
Income	7.61	
		1,237.33
Total Funds		$2,453.31

STATEMENT OF REVENUE AND EXPENSE
ONE YEAR ENDED MAY 31, 1945

REVENUE

Dues	$ 6,114.00
Income from Investments	420.86
C. M. A. B. Advertising	4,028.12
Local Advertising	1,148.68
Subscriptions and Sales of JOURNALS	16.20
Exhibit Space Rentals	826.00
Total Revenue	$12,553.86

EXPENSES

Salaries:—		
Dr. Carter — Secretary, Treasurer and Editor	$2,200.12	
Mrs. Kennard—Assistant Secretary	2,000.00	
Travel — Secretary and Councilors	75.99	
Office Expenses:—		
Supplies and Stationery	229.25	
Postage and Mailing Expense	168.87	
Rent	300.00	
Telephone	158.24	
Light	12.00	
Auditing	69.51	
Books and Magazines	24.00	
Miscellaneous	74.54	
A. M. A. and N. E. Meetings	223.64	
Medical Advisory Committee	500.00	
Annual Meeting	890.05	
Five-Year Service Bar	6.00	
Contributions to War Finance Committee	177.75	
Printing	4,370.27	
Plates	57.55	
Total Expenses		11,537.78
Revenue in Excess of Expense — One Year		$1,016.08

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
ONE YEAR ENDED MAY 31, 1945

Cash in Banks, June 1, 1944		$15,540.65
RECEIPTS		
Received from Dues	$6,246.00	
Income from Investments	420.86	
Exhibit Space Rentals	504.00	
Subscriptions and Sales of JOURNALS	16.20	
Advertising	4,833.40	
Withholding Taxes	411.20	
Mortbon Corp. of N. Y. "D" 5's, 1956, called at 100	500.00	
		12,931.66
		$28,472.31

DISBURSEMENTS

Salaries	$4,200.12	
Traveling and Other Expenses	75.99	
Office Expenses	1,052.08	
A. M. A. and N. E. Meetings	223.64	
Annual Meeting — 1944	875.42	
Medical Advisory Committee	500.00	
Five-Year Service Bar	6.00	
Printing and Plates	4,427.82	
Women's Field Army (Multigraphing)	4.25	
Withholding Taxes	386.10	
Purchase of $4,000 U. S. Savings "C" Bonds	4,000.00	
		15,751.42
Cash in Banks — May 31, 1945		$12,720.89

Canal National Bank — Checking Account	$4,888.54	
Canal National Bank — Savings Account	1,687.49	
Maine Savings Bank	2,859.39	
Portland Savings Bank	2,819.10	
First National Granite Bank	466.37	
		$12,720.89

SECURITIES
MAY 31, 1945

BONDS

$2,000 Commonwealth of Australia, Ext. Loan 30-Yr. 5's, 1957	$1,960.00
$3,000 Portland Terminal Company, 1st Mtge. 5's, 1961	3,045.00
$700 Prudence Bond Corp., 1st Mtge., Coll. Series 6, 5½'s, 1936 (Defaulted)	700.00
$4,000 U. S. Savings Bonds "G", due July, 1956	4,000.00

STOCKS

10 Shares Mortbon Corp. of N. Y. (Par $1)	60.00
	$9,765.00

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, August, 1945 No. 8

*The Government, The Physician and National Health**

Lloyd H. Berrie, M. D., Caribou, Maine

Congress will soon consider new legislation that will, directly or indirectly, concern every American. If these proposals are enacted into law, a vast new bureaucracy will be created that will place several thousands of additional employees on the government payroll. Its enactment will be against the sincerest opinion of our organized professional judgment whose major counsel has not been sought by the bill framers. I refer, of course, to the Wagner-Murray-Dingell Bill to whose content the very great majority of physicians in this country are opposed.

This Bill can, by the circumstances which it would create, place doctors, hospitals, and other medical institutions under government supervision and control by the creation of a national compulsory health insurance. In Senator Wagner's words "135,000,000 people will be benefited." The Bill completely disregards the majority opinion of the 125,000 physicians who constitute the American Medical Association, and who provide the major portion of medical care for the people of the United States. It also disregards the opinion of 60,000 physicians now in the armed forces who have sacrificed as much as any other group in the country during the present war. This obstinacy is typical of the manner in which the sponsors of this bill have written it according to their own notions of how medical care should be rendered.

With few exceptions, the members of our medical profession believe that government control of medicine, through the creation of a national compulsory insurance will lower our standards of medical education and efforts, regardless of the tempting form with which it is presented.

We doctors of medicine, who are concerned solely with the causes and cure of disease, and who know this subject best, are apprehensive lest the lassez-faire attitude of the uninformed public will permit this legislation to become a law that will, on the surface, appear to be a panacea to the nation's health, but that actually will waste large sums of money and will undermine and thwart medical and non-medical initiative and progress here at home.

Although it *is* true that this country enjoys

* Read before the annual Aroostook Society meeting, June 19, 1945.

Note: The subject matter of this paper is largely material taken from a wide variety of publications that have appeared throughout the last few years.

better medical care and health than any country of comparable size in the world, it is also true that there are many areas in our country where good health standards are lacking, and sometimes deplorably so. But it should be made clear, at once, that the needs in those areas that are inadequately supplied with medical personnel and good sanitation, cannot properly be used as a reason for subjecting to government control the most of the country, where better health standards and facilities are available. Neither does it in any way make sense to enclose the whole structure of society in a nationwide compulsory health insurance or tax because there happens to be indigent members belonging to that society. This is not American in nature or consistent with our heritage as free men.

The mortality and morbidity rate of this country has steadily decreased for many years. This has been due mostly to the high standards of medical training for which the AMA has created the greatest organized impetus. With the discovery and intelligent use of a host of new medical and surgical procedures these last years, we are saving the lives of countless numbers who otherwise would have been doomed. Indeed, a dramatic new era of medical healing is rapidly unfolding. Our medical institutions are geared to that end. They must be left alone. The fact that this country now enjoys the highest standards of medical care in this world is *primarily* the result of the efforts of the individual doctor of medicine.

It is becoming increasingly evident that a most important factor for success in the treatment of disease is an understanding of the personality of the patient. No laboratory test can perform this appraisal. The patient's background, emotions and mode of living have a considerable influence upon the pattern of his disease. Intelligent medicine can be practiced only when the relation between doctor and patient is sympathetic and personal. In England, where state medicine was adopted by the government, against the advice of their medical profession, the incidence of sales of "patent medicines" and home remedies have greatly increased as has the incidence of preventable disease. These are examples that tend to indicate that highest standards of medical practice cannot be maintained efficiently when responsibility to the government replaces responsibility to the patient.

The state medicine resulting from a national health insurance plan will necessitate the interposition of a third party between doctors and patients as a controlling factor. The doctor will be responsible to that third party. It will mean the establishment of at least two or more government employees, who have no medical knowledge, for every participating doctor. A vast new expenditure will be created for a new bureaucracy of employees who will not be easily controlled or removed.

The particular target for the proponents for a compulsory health insurance is our American Medical Association. From the propaganda that has been appearing in current publications during the past year a general impression has been created that this medical organization exists in order that M. D.'s may enjoy an unlimited privilege of "fleecing the public."

125,000 doctors of medicine, from all over the country, belong to the AMA. They created it. It is a non-profit organization whose sole purpose has been and is to advance the standards of medical practice and knowledge. The AMA has encouraged the closure of medical schools that were little more than "diploma mills." It has consistently and effectively raised the standards of existing medical schools and hospitals. It has exposed thousands of nostrums, quacks, and cults. It publishes up-to-date literature in all the various fields of medicine. It maintains numerous essential counsels. The counsel on pharmacy and chemistry, for example, subjects all new remedies or drugs to severe and exacting tests before they are accepted and recommended for use to the medical world. It has consistently been opposed to any plan that might prove detrimental to the progress of medical science.

The concept of paying the government a few dollars yearly as an insurance of "free medical service" is bound to be attractive to the majority of citizens in the low and medium income group, since many of them go about shaking their heads over the "high cost of medical care." They forget about the other items—hospitalization, nursing, medicines, dental care, etc. —that consumes 70 per cent of the medical dollar. They do not appreciate that the average physician's training represents about $15,000.00

of investment, and this does not include the one to three years of hospital training that the majority of medical school graduates pursue in addition, especially during these last fifteen or twenty years. Until the onset of the present war, most of us spent from nine to thirteen years of training in colleges and hospitals before we commenced our private practice. If one multiplied those years by an average weekly wage that might have been earned otherwise, at least double the above figure would be obtained. Yet a fairly recent Medical Economics income and expense survey indicated that our average physician's net annual income was around $2,792.00. A good many physicians earn many times that figure. In most instances their earnings keep pace with their skill, or it may sometimes be due to economic and geographical advantages.

Should regimentation prevail it is difficult to conceive how our present medical profession could possibly cope with the onrush of patients who would besiege their offices with trivial and bizarre complaints beyond numbers regardless of the terms of their government policies. In addition, the physician will be obliged to make reports on every person so insured, perhaps in duplicate, triplicate or whatnot, to a central bureau. Since a good many older physicians, who are able to do so, would retire rather than yield to state control of their means of livelihood, the shortage of medical care would increase further.

It is felt that regimentation of medicine would destroy the competitive nature of medical practice and learning. This is something that the lay mind cannot grasp. It is quite impossible to emerge from modern training without an inquisitive mind and a desire to progress in medical knowledge. Regimented medicine will act to destroy that progressive urge. One wonders if, in the future, that intangible something that urges men and women of high character to study and accept the challenge of medicine will be lost, and that politics will influence the choice and formation of medical character.

It is in the field of public health and preventative medicine that governmental help is actually needed if we are to become a healthier people as a whole. In this respect intelligent governmental aid can certainly operate to create a better health future for our country. It is as ridiculous to blame the medical profession for our isolated areas of inferior health standards as it would be to blame our fire departments for the occurrence of isolated fires.

In order to better control the causes of preventable illness, this country needs, most of all, a single national bureau of health in Washington. This could seemingly best be done by creating a Secretary of Health. Such a cabinet department, if it were efficiently organized, would permit a single, correlated agency to study and recommmend beneficial health measures to be taken, where the need is definitely clear. A bill sponsoring the creation of such an executive department has already been introduced to Congress, but it is reported to be strongly opposed by many factions, including the most recent succeeded Secretary of Labor, and many labor leaders, for reasons that are not generally clear.

Federal aid, for example, is needed in the way of grants and loans to assist in the provision of sewage and water facilities, milk pasteurization, and water pollution in many areas of our country. If the highest level of sanitation were maintained in these phases of our national life alone, we would be a healthier nation.

More adequate provision should be made for the deserving needy through increased appropriation by federal, state and local governments to existing agencies. Such people usually receive a pittance of the amount of funds that are adequate to obtain sanitary shelter, clothing and food.

The government should provide funds for new hospitals where they are needed. One of the major disadvantages of our present medical training program is the reluctance of young doctors to locate in rural communities where there are no hospitals. The situation arises from the fact that modern medical training is closely linked with the hospital and laboratory. This is one of the leading causes of inadequate rural medical care. It will be futile, wasteful and ridiculous, however, to build hospitals when adequately trained medical skill is not available to use them. In order to provide such medical personnel, it will take several years of preparation and training, possibly with government scholarships or loans available to qualified students desiring medical education. It should also be a matter of federal concern to see to it that

a definite set of high standards are created for all medical schools.

There should be a ban on medical or related advertising to the public. As far back as 1930, a survey showed that the people in the United States spent some $360,000,000 annually on "patent medicines" of secret composition. This is a little more than half the total amount spent during the same period for all medicines. It was also shown that another $165,000,000 was spent for non-secret medicines as home remedies. This is a most vicious form of semi-quackery because thousands of people are duped into treating ailments at home that often develop into irreparable disease.

Some provision should be made to provide for a periodic medical examination of school children. This is done now, here and there, but the examinations are, in most instances, not thorough and complete. This might prove to be one of the most practical measures in preventative medicine, and it seems logical that such a plan, if intelligently carried out, would forestall many tragedies of middle life.

These are but a few of the ideas which our profession has suggested. They are not considered as such in the Wagner-Murray-Dingell bill.

Compulsory health insurance is a misnomer. It concerns not health but sickness. It is not insurance but a tax. Its operation in many countries has nowhere given it as satisfactory a record as the American system based on free enterprise. Under compulsory insurance preventable diseases increase. This system encourages malingering. It interposes a third party — the government — between the doctor and patient, and the doctor is responsible to that third party and not to the patient. There is usually an eventual interference with free choice of physician. A poor type of medical care is encouraged. The government will interfere with prescribing and dictate the number of visits a doctor may make. The government labels each physician and specifies what or what not he may do. The doctor becomes a certificate writer rather than a family counselor. The system does not reach the unemployed. Finally, it is inordinately expensive and results in a tremendous bureaucracy with inevitable red tape and bureaucratic inefficiency.

The medical profession cringes from the thought that individual enterprise will be abolished and that we will be reduced to the status of the "common man." We are all common men but not in this newly planned sense that we all wish to be common. We do not wish to be reduced to the colorlessness of the crowd. Winston Churchill said, not long ago, "I hope to heaven we are not fighting this war dedicated to the cause of commonness."

We cannot, must not submit to any scheme of ill-advised politicians who would interfere with the truly great progress and record of the medical sciences, nor permit them to legislate successfully "ideologies" that disregard the history, complexity and slow evolution of human progress.

The slow, sometimes hidden trend toward socialism in our country which seemed to be emerging before the present war in some ways, and which, because of the war, has been enhanced of necessity in many instances, may be gradually and incipiently reversing Lincoln's doctrine of the People's government, to that of the Government people.

Sound public health practice demands that the method used in mass radiography for the control of tuberculosis be one which benefits the largest number of persons in industry or the community. When available funds are limited, it is of greater value to examine 100,000 persons with small films and miss a few minimal cases than to examine only one-tenth of that number at about the same cost, using large celluloid films and leaving 90,000 persons without benefit of any X-ray examination whatever. H. E. Hilleboe, M. D., and D. M. Gould, M. D., *Jour. A. M. A.*, May 24, 1944.

The symptom complex, which is commonly called the onset of tuberculosis, is not the onset but the stage of active progression, characterized by cough, fever and night sweats.—Esmond R. Long, M. D.

"Senate Bill 191"

By A. G. Eustis, Treasurer, Colby College; Trustee, Thayer Hospital

Senate Bill 191, known as the Hospital Construction Bill introduced into the Senate in January of this year, provides for the authorization of an appropriation by the Federal government to facilitate construction of public and voluntary non-profit hospitals, clinics, and health center facilities throughout the country. State surveys are to be made concerning hospital needs and the results of the surveys are subject to the approval of a Federal Advisory Council. The Surgeon General is charged with the responsibility for establishing standards for studies, for State plans and for approving grants. In all his activities the Surgeon General must have the approval of the Federal Advisory Council. The Federal Advisory Council would be appointed by the Federal Security Administrator. It is intended that the Council shall be composed of outstanding authorities in the hospital and medical field.

Money appropriated by the Federal government would be on a matching basis. In determining the proportion of cost to be advanced by the Federal government, the population in each State, the relative wealth, and the special needs would be the determining factors.

The legislation was formulated after careful study and consultation with many groups including the joint committee of the three National hospital associations and the Associations support the legislation.

As one consistently in opposition to the New Deal centralization of power, and the constant extension of Federal control, and as an opponent of so-called socialized medicine, as provided in recently proposed legislation, I find myself in the curious position of strongly favoring Senate Bill 191.

I want to examine with you my reasons for arriving at this decision.

1. The plan calls for a State survey. Our hospital system has to a large degree developed in a non-planned and haphazard way. There has been a distinct lack of careful planning taking into consideration the over-all needs of the State. The proposed survey would be made by a designated agency assisted by an advisory council. This survey would determine an over-all program for the State and would determine the priority or order in which new construction would be carried out. It is expected that the survey could be financed, at least in part, through Federal funds.

Such a survey should result in a detailed and careful analysis of the State's problems and deserves and needs the whole-hearted support of all hospital trustees, medical and hospital associations and any others interested in the general health of the public. All of us should support the survey without selfish interest and with the broad needs of the State in mind. If Federal funds do not become available for possible construction it is my judgment that the surveys alone would mark a definite step forward.

2. The need is great. It is obvious that we need more hospitals properly located. A survey made over a year ago indicated the need of 181,000 more hospital beds at a cost of $1,193,000,000.00. The time is rapidly passing when we can depend on private philanthropy to meet this need. Furthermore new emphasis needs to be placed on health centers and so-called group medical facilities.

Especially is the need great in small community hospitals such as most of us here represent and which occupy an important place in the hospital field. Such hospitals, to adequately fulfill their functions, must be assisted in coordinating their activities with the public health activities of the community.

3. The emphasis in the bill is on administration at State levels. This seems to me to be worthy of great stress. We are opposed to so-called socialized medicine yet we must move with the times. Voluntary participation is greatly to be favored over any compulsory hospitalization plan. Senate Bill 191 seems to offer

Continued on page 147

Read before the Regional Hospital Conference — Belfast, April 25, 1945.

The President's Page

To the Members of the Maine Medical Association:

Medicine is "at the crossroads",—one path is the road towards continued medical freedom of practice and the other is veritably, the road to serfdom. These may be strong words and my phraseology ill-timed, but I am willing to stand by them! There may be those who scoff at such a statement but be assured that the next few years will be most important for us and our decisions must be sensible and our plans for the future well thought out, if we prefer to be free practitioners of medicine rather than mere slaves of bureaucrats.

I don't like to be "compelled" to do anything! You don't like it either! It annoys any red-blooded, true American physician, to be told how he must practice medicine!

The "handwriting is on the wall" and we must agree that the insurance principle is growing, whether we like it or not. The very words "Compulsory Health Insurance" arouse, in most of us, a violent antagonism and a bitterness towards those who bring forth such ideas. I am—and have been—since the start of the controversy, an opponent of Compulsory Health Insurance in any form.

We must give this matter immediate thought and attention and at the coming County Medical Society meetings let us decide, once for all, whether we are to be "sold down the river" or shall we take a stand and fight for our rights and privileges.

It demands a lot of thought, and maybe some experimentation, before we find out whether mutual companies, developed through our State societies, the Blue Cross Plan, private insurance companies or medical group plans will be the answer to "Compulsory Health Insurance."

Let us not do anything which would meet with the disapproval of the medical brethren now in the Armed Services. If any body of men has a right to be heard, it is they!

If we must have some type of "insurance", and if it is true that there is obvious need for better distribution of medical care, I am quite certain that the so-called medical group idea offers the best solution. While in California, this past winter, I had the opportunity to observe the Ross-Loos Medical Group in actual operation. It is a sensible, business like, and satisfactory proposition. It offers an even "break" to the Medical Profession and to the public. I look forward to the time when I may discuss it with you.

Adam P. Leighton, M. D.,
President, Maine Medical Association.

Editorial

Why New Wagner Bill Is Socialized Medicine

The new Wagner-Murray-Dingell bill, which would expand the Social Security Act to cover almost every phase of medicine, is still socialized medicine, says Morris Fishbein, M. D., in an editorial in *Hygeia, The Health Magazine,* because the measure still fosters "a system of medical care administered by the federal government and controlled through funds which are held in the hands of the federal government."

Dr. Fishbein's editorial, appearing in the July issue of *Hygeia,* which is published by the American Medical Association, says:

"Again the American people have witnessed great headlines in American newspapers dealing with Social Security. Senators Wagner and Murray in the Senate and Congressman Dingell in the House of Representatives introduced a measure which would tremendously expand the Social Security Act. Among other proposals the 1945 version would provide $50,000,000 the first year and $100,000,000 every year thereafter for nine additional years to be spent in building hospitals and health centers. It would greatly increase the number of people now covered by the unemployment and old age plans. It would increase the grants now made to the states for public health services, for maternal and child health and welfare services, for the aged, for dependent children, the blind and other needy persons. It would set up a national system of public employment offices. It would extend greatly the grants made to the individual states for the control of venereal disease, tuberculosis and other disease control measures and would almost double the appropriation for administrative expenses usually given to the United States Public Health Service. All this, and the setting up of a system of complete medical care for everybody in the United States, would presumably be accomplished by a tax on the payroll representing four per cent for the employer and four per cent for the employee. (Incidentally, the four per cent is to be charged against the first $3,600 a year rather than $3,000 a year—the limit set by the present Social Security Act and that proposed in the previous Wagner-Murray-Dingell bill. People who are self-employed will pay five per cent of the market value of their services subject to the same ceiling limitation.) Even with this tax, which is considerable, economists wonder whether the sponsors have not actually underestimated the total cost of what they propose to accomplish.

"The complete control of medical care is vested by this measure in the Surgeon General of the United States Public Health Service, who is to have the advice of a national advisory medical policy council which he himself appoints but whose advice he does not have to take. Almost every phase of medicine is covered by the bill, including the provision of care to the sick, examinations necessary for the prevention of disease, all sorts of specialistic and laboratory services, hospital care, home nursing and dental care. Moreover, funds are to be set aside for research and for the education of physicians and other medical personnel.

"Those who promote this bill avoided, as if it were a plague, the word compulsory. Nowhere is that word used in any of their discussions. Indeed, they keep on saying in the speeches that they are already making about the bill, that every one will have complete freedom in choice of a doctor and that doctors will have complete freedom in choice of patients. Senator Wagner says, 'Health insurance is not socialized medicine; it is not state medicine.' This would seem to be quibbling. If the federal government establishes a system of insurance to which every one must contribute, if the federal government regulates the provision of medical service through a Washington headquarters, if it regulates the fees that doctors are to receive when they participate in the system, if it regulates those who are to be consultants and when the consultants are to be consulted, it certainly is a system that is both socialized medicine and state medicine.

"True, the present measure tries to decen-

Continued on page 147

CONSTRUCTIVE PROGRAM FOR MEDICAL CARE

AMERICAN MEDICAL ASSOCIATION

This platform was adopted by the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association on June 22, 1945.

Preamble

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

Program

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives:

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular army, navy and United States Public Health Service.

Prevention or Modification of Measles

By Roscoe L. Mitchell, M. D., Director of Health

For many years serious efforts have been made at times by state and local health departments to control the spread of measles. In spite of such efforts, epidemics have continued on their way until a large majority of susceptible children, and some adults who have escaped previous epidemics, have had the disease. It is well known that measles proves most serious in end results in the very young and in old persons. Non-specific protein therapy and preventive measures have been tried in the past without achieving popularity with the profession, which circumstance may be attributed in part to undesirable reactions accompanying the use of such materials as have been available.

During the processing of human blood plasma by various manufacturers under the sponsorship of the American Red Cross, fractional separation of human gamma globulin has been successfully accomplished on a large scale, and the preparation has been made available to state health departments for free distribution to physicians for their use according to accepted standards in preventing measles or modifying the severity of the disease. The human gamma globulin is said to possess all the advantages of older preparations, and to be free of most of the disadvantages.

The Bureau of Health has a supply of this material and will be glad to send it in reasonable quantities to physicians on request. From the public health standpoint its use for modification of the disease would be preferable. In this way permanent immunity would be attained by the individual.

The following data concerning the material and its use have been made available by the American Red Cross with acknowledgment of the author.

Normal Serum Gamma Globulin Antibodies (Human) Concentrated (Immune Serum Globulin) *

1. *What is this material?*

This preparation is a concentrate containing the antibody globulins derived from pooled normal human plasma collected by the American Red Cross.

2. *What is its potency?*

Preparations of Gamma Globulin Antibodies are standardized so that the concentration of antibody is 25 times that of the plasma pool from which it came. Since each pool is obtained from several thousand donors, variations in titer of measles antibody should be slight. Each preparation is tested for potency in the laboratory by tests for antibodies which can be readily measured. Whenever possible its potency is checked in a series of patients exposed to measles before release for general use.

3. *Stability*

This material should be kept in the icebox like other biologicals. The dating period at present is set at one year. It is probable that it will retain its potency for longer periods of time.

4. *Indications*

At present this material is released *only* for the prevention and modification of measles by passive immunization. Other possible uses are being studied, but insufficient data are available to evaluate its efficacy in these circumstances. Its use in the treatment of measles or the treatment or prophylaxis of other childhood diseases is not recommended at present.

5. *Administration and dosage*

This material may be administered when indicated to patients who have had a definite exposure to measles in the infectious stage. Its use to prevent or to modify the disease is at the discretion of the physician.

For prevention—A dose of .08-0.1 cc./lb. body weight should be given as soon after exposure as possible, but will be fairly effective in the first seven days.

For modification—A dose of .02-.025 cc./lb. body weight should be given on or about the fifth day after first definite exposure.

Method of administration—The globulin is injected *intramuscularly,* preferably in the buttocks. For this, a 20- or 21-guage needle is most satisfactory. Pull back on plunger of syringe before injection to be sure needle is not in vein, *since globulin as now prepared must not be used intravenously.*

Caution—The globulin is a concentrated protein solution, hence viscous and sticky. Do not fill syringe until prepared to make injection, otherwise syringe may become frozen.

Jaundice—Blood, plasma, and serum have been found on occasion to contain a jaundice-producing agent. Therefore, it is possible that fractions derived from plasma may contain a similar agent. Such jaundice appears 2-6 months after injection. No jaundice has been attributed to this material so far, but careful records of its use should be kept so that any cases of jaundice occurring 2-6 months after injection may be traced to the particular lot concerned.

---

* Prepared by C. A. Janeway, M. D., Harvard Medical School, Department of Pediatrics, for distribution by the American Red Cross.

Continued on page 146

Necrologies

Bertrand F. Marshall, M. D.,
1866-1945

Bertrand F. Marshall, M. D., 78, died at his home in Westbrook, Maine, June 22, 1945, after an illness of two days.

He was born October 31, 1866, at New Gloucester, Maine, the son of the late Doctor Albert Marshall and Helen Dunn Marshall. He attended Edward Little High School, and Bowdoin College, and received his medical degree from Dartmouth Medical College in 1888. He practiced at South Windham, Maine, and Waltham, Massachusetts, before locating in Westbrook in 1918. He had served as city physician and school physician for several years.

Doctor Marshall was a member of the American Medical Association, the Maine Medical Association, and the Cumberland County Medical Society. At the 1938 annual meeting of the Maine Medical Association he was presented with the Association's Fifty-Year Service Medal.

He is survived by a son, Orland Smith Marshall, M. D., of Billerica, Massachusetts, a daughter, Mrs. Gladys M. Foss of West Asheville, N. C., a sister, Mrs. Clayton Boothby of Meriden, Connecticut, five grandchildren, and two great-grandchildren.

Charles E. Thompson, M. D.,
1875-1945

Clarence E. Thompson, M. D., 69, died at his home in Saco, Maine, June 2, 1945.

He was born in Lewiston, Maine, July 13, 1875, the son of James Marriner and Katherine Keith Thompson. He attended the public schools in New Gloucester, Maine, and was graduated from Bowdoin Medical School in 1901. He served his internship at the Eastern Maine General Hospital, Bangor, and started his practice in Saco in 1902, remaining there to the time of his death.

Doctor Thompson was a member of the American Medical Association, the Maine Medical Association, and the York County Medical Society, and had been a member of the surgical staff of the Webber Hospital, Biddeford, since its institution. He was a past president of the Biddeford-Saco Rotary Club, past master of Saco Lodge, F. & A. M., and a past district deputy of the Masonic Grand Lodge.

Surviving are two sisters, Mrs. Ada Kemder of Salem, Massachusetts, and Mrs. Ethel Pinkham of Portland, Maine.

COUNTY SOCIETIES

Androscoggin
President, Romeo A. Beliveau, M. D., Lewiston
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Fort Fairfield

Cumberland
President, Henry P. Johnson, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Francis A. Winchenbach, M. D., Bath
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Hancock

A regular meeting of the Hancock County Medical Society was held at the Belmont Hotel in Bar Harbor, Wednesday evening, July 18, 1945.

Four members of the Penobscot County Medical Society and one member of the Waldo County Society were present, as well as two members of the Staff of the Jackson Memorial Laboratory.

The Honorable Frank Fellows was a guest of the Society at the meeting.

Dr. C. C. Little, of the Jackson Memorial Laboratory in Bar Harbor, spoke very interestingly on the general subject of cancer problems. This was followed by a period of general discussion.

J. H. Crowe, M. D.,
Secretary.

Washington

The Washington County Medical Society held a special meeting, July 27th, at the St. Croix Hotel, Calais, Maine.

Following a lobster dinner served at 6 P. M., Dr. Raymond V. N. Bliss of Blue Hill presented one of the finest addresses this society has had the pleasure of hearing. His development of the life and influence of Dr. William Halstead was most interesting and instructive.

The meeting was adjourned at 8:45 P. M. Twenty members were present including Lt. Comdr. Norman E. Cobb from Camp Lee-Stephenson, Quoddy, Maine.

Allen H. Knapp, M. D.,
Secretary.

Book Review

"Men Under Stress"

By: Lt. Col. Roy R. Grinker, M. C., and Major John P. Spiegel, M. C., Army Air Forces. The two army doctors who set up the first Army Air Forces convalescent hospital exclusively for operational fatigue in the country.

With 484 Pages. 20 Chapters.

Published by The Blakiston Company, 1012 Walnut Street, Philadelphia, Pa. Price, $5.00.

This book records the experience of military psychiatrists working with combat soldiers overseas in an active theatre of operations, and returnees suffering from war neurosis hospitalized for rehabilitation.

It describes sixty-five case histories in detail, also the treatment and results. It is of value to those in military and civilian life who are interested in human beings under stress, and the methods of treatment now available.

Prevention or Modification of Measles—Continued from page 143

6. *Safety*

A great many *intramuscular* injections have been given without any serious reactions and with very little local pain in the dosage recommended. Rarely, fever, irritability, or tenderness of the site may follow injection in the first 24 hours.

7. *Duration of effect*

A single dose will probably protect a child for about 3 weeks. At the end of that time, if the child is re-exposed and protection is desired, the dose should be repeated.

8. *Results of injection*

With any biological system, in which the virulence of the virus and the resistance of the host may vary considerably, some variation in results is to be expected. With the small doses used for modification, a few patients will develop typical measles; with the large dose, used for prevention, a certain number will fail to develop any evidence of measles.

Mild measles which results from a satisfactory modification may vary from a disease only slightly milder than the average case to one that exhibits only one or two of the stigmata of measles. Malaise and fever are usually markedly reduced, the catarrhal symptoms slight, and rash may be evanescent and sparse.

References

1. Cohn, E. J.; Oncley, J. L.; Strong, L. E.; Hughes, W. L., Jr.; and Armstrong, S. H., Jr.—Chemical, clinical, and immunological studies on the products of human plasma fractionation. I. The characterization of the protein fractions of human plasma. *Journal of Clinical Investigation*, 23:417, July, 1944.

2. Enders, J. F.—Chemical, clinical, and immunological studies on the products of human plasma fractionation. X. The concentrations of certain antibodies in globulin fractions derived from human blood plasma. Ibid., p. 510.

3. Stokes, J., Jr.; Maris, E. P.; and Gellis, S. S.—Chemical, clinical, and immunological studies on the products of human plasma fractionation. XI. The use of concentrated normal human serum gamma globulin (human immune serum globulin) in the prophylaxis and treatment of measles. Ibid., p. 531.

4. Ordman, C. W.; Jennings, C. G.; and Janeway, C. A. — Chemical, clinical, and immunological studies on the products of human plasma fractionation. XII. The use of concentrated normal human serum gamma globulin (human immune serum globulin) in the prevention and attenuation of measles. Ibid., p. 541.

5. Greenberg, M.; Frant, S.; and Rutstein, D. D.—"Gamma globulin" and "Placental globulin." A comparison of their effectiveness in the prophylaxis of measles. To be published.

6. Janeway, C. A.—Clinical use of products of human plasma fractionation. I. Albumin in shock and hypoproteinemia. II. Gamma-globulin in measles. *The Journal of the American Medical Association*. To be published.

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Belfast	Waldo County	2nd Friday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Lewiston	Central Maine General St. Mary's General	1st Monday 2nd Monday
Portland	Maine General Mercy	2nd Friday 3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters Thayer	2nd Tuesday Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

"Senate Bill 191"—Continued from page 139

adequate protection to the hospital from the danger of Federal control. The Bill puts it up to the State to develop its own program for hospital and health center construction.

4. We hear much about plans for full employment after the war. Each such plan includes provisions that from time to time public works programs will be necessary. If public funds are to be used in this manner, hospitals and health centers are worthy of being given a high priority. Such expenditures, if carried out as a result of careful planning such as is contemplated, would be of an undoubted value to all our citizens. This would be a happy contrast to the situation of much of the "made-work-program" of the '30's.

In conclusion we must keep in mind that buildings and equipment alone do not make a health center.

Editorial—Continued from page 141

tralize administration as much as possible. It tries to take in existing plans; it tries to meet the criticisms that have been made as to free choice of doctor and methods of payment of the physician. But, try as its proponents have tried, the measure still remains a system of medical care administered by the federal government and controlled through funds which are held in the hands of the federal government. Most of the arguments which were made against previous versions of the Wagner-Murray-Dingell bill can be made with equal justice against the present versions. To them should be added the additional arguments that become necessary because this bill has so much more to say about how it's all going to be done."

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, September, 1945 No. 9

*Presidential Address**

R. V. N. Bliss, M. D., Blue Hill, Maine

In this, my final message as President of our Maine Medical Association, I should like to thank you for coöperation, kindness, and tolerance during my year of service. I should like also to congratulate you for having chosen as my successor the colorful and vigorous Adam P. Leighton, doctor of medicine, champion of human rights, and, fortunately for all, guardian of the Kittery Bridge. The quality of our membership today testifies mightily for his ability and discretion in the last thirty years.

Thirty years, three decades! What a wealth of accomplishments in medicine and surgery this period of years records. We have never been addicted to recounting our own glorious achievements, feeling, as most of us do, that in the matter of newspaper items concerning the accomplishments of physicians there is always a faint, but ever present suspicion of hypocrisy. Our own journals are devoted to records of scientific progress rather than to panegyrics. Whatever our personal limitations may be in the field of self-appraisement we are not ignorant of the obvious fact that in three decades no other profession, and certainly no business, can lay valid claim to accomplishing half as much for the human race. In the light of our achievements, our relative freedom from commercialism, our availability and our selflessness in treating rich and poor alike, we have been startled and hurt to find ourselves and our services included in the pawn of politicians.

Ours was the only free organization, the only group which could not be made to pay tribute to unionism. Organized labor, feeling its swelling muscles and reveling in its fecund power, conceived the idea of making its members a number of lavish gifts, including personal security from cradle to grave, pay without work, and, for good measure, prepaid and packaged medical care. Why not? The doctors are numerically weak, intelligently tolerant, unorganized, predisposed to be unaware of evil. Indeed, why not force the politicians to hand over the medical profession as a gift ostensibly to the Federal Government, actually to organized labor. Then by the maladroit employment of propaganda, radio and press were commissioned to charge the medical profession with incompetency and utter failure to furnish adequate medical care for all persons. Then came the false facts, the highly inaccurate statements regarding medical care in the United States.

* Presented at the meeting of the House of Delegates of the Maine Medical Association at Augusta, Maine, June 24, 1945.

"Nothing lies like statistics," so statistics were invoked; and it was revealed that, when all the disabilities of the draft dodgers were counted, the young men of the country were very sick from causes which good medical care should have cured or prevented even without the consent of the afflicted. Then the bright ones, finger on nose, intoned that "medical care" was so very expensive in the period between wars, and so poor in quality, that the knees of these young men could not be strengthened; hence, they wabble in war time.

Obviously the best vehicles were the generally loose and unmoral Wagner, Murray, Dingell bills. These politicians, to carry favor with the labor vote, have done their best to deliver the thing called "Medical Care;" but the package generated heat, lost its original shape, languished in committee. In short, it has not yet been delivered, despite the deep-rooted, long-standing demand for it said to have existed in the "hearts of the people."

Of all the reactions engendered by this threat of socialized medicine, that of the Maine Medical Association seems, to me, the sanest. We have not allowed ourselves to be tumultuously herded into the tyranny of any substitute, nor have we been driven to panic by the threatened Federal Bill itself.

Socialized medicine should be of greatest concern to patients, and it is they who will finally decide for or against it.

It is possible that the quacks have greater cause for concern over the proposed legislation. On some dark and windy Washington heath they may have need to consult those three weird sisters, the political opportunist, the corridor buzzard, the professional hireling.

Of far greater importance, to us, is our own attitude toward the flagrant, legalized, quackery in our State. It flourishes because certain doctors of medicine prostitute their art and practice by standing ready to catch the quack when he would fall.

Any such physician or surgeon who lends aid or succor, by any of the various means by which he may do so, to any brand of quack is obviously unworthy to be a member of the Maine Medical Association. It is impossible to accept referred cases from these poorly trained practitioners without sooner or later compromising our own standards. A surgeon who accepts a case complaining of abdominal pain and branded with acute appendicitis by the quack who refers him, must operate if he expects to get the next referred case. Hence the great increase, in some communities, of Acute Remunerative Appendicitis. Complications accumulate until surgeons, and consultants in other specialties, are easily classifiable if they traffic with quackery.

A patient who has chosen a quack for his physician is within his rights and should be allowed to stand by his decision to the end.

An evil cannot be legislated out of existence, but it can perish for lack of supporters to aid and abet its practices.

Let us tighten our organization until it includes an oath of utter devotion to the highest principles of medical practice. Our individual background, our liberal education and training should make any other course abhorrent.

In the latter half of these three decades another cause for real concern has been the reckless rise of propaganda and the loose regard for truth in high places. The American public has never before been treated as a juvenile mob incapable of thinking for itself even in the simplest matters. The sheer presumption of a fairly recent series of events concerning the alleged shortage of trained nurses is a case in point. You will recall that every radio program ended on a sad note to the effect that a deplorable need for six thousand nurses existed in the armed forces.

Reiterated and explicit were statements that even if no more wounded men were to come from Europe, those already in hospitals could not be given nursing care. A bill to draft nurses passed the house, suffered delay and smothering in the Senate; and, before the threatening propaganda in the newspaper and radio could be stopped, the Red Cross calmly announced that no more voluntary enlistments of nurses would be accepted, for the simple reason that they were not needed. That both these conditions of shortage and surfeit existed in the same month is not within the limits of truth. This and other equally flagrant exaggerations do not tend to inspire confidence in statistical sources at the fountainhead of power.

Now as another devastating war approaches its end, the second holocaust of planned murder in this period of three decades, praise unstinted is showered upon the medical profession for

Continued on page 155

*The New Wagner-Murray-Dingell Bill and S. 191**

George Bugbee, Executive Secretary, American Hospital Association

Upon examination the new Wagner-Murray-Dingell Bill is found to be significant in the hospital field for more than one reason. The authors have changed some details in the formula for compulsory federal health insurance. While they have made some effort to heed criticisms of their old measure, they have retained the substance of compulsion on which all those criticisms were based. They have included in their omnibus measure a somewhat retailored version of S. 191, the hospital construction bill.

The new, revised and expanded Wagner-Murray-Dingell Bill was introduced May 24 in both branches of Congress—as S. 1050 and H. R. 3293. In presenting this legislation Senator Wagner made statements which might be misconstrued unless accurately quoted and understood. He said in part:

"The bill incorporated the constructive suggestions of many organizations and persons, including the American Federation of Labor, the Congress of Industrial Organizations, the Physicians Forum, the Committee of Physicians for the Improvement of Medical Care, the National Catholic Welfare Council, the American Hospital Association, the American Public Health Association, the National Lawyers Guild, the American Public Welfare Association, the American Nurses' Association, the National Organization for Public Health Nursing, the National Farmers' Union and the American Foundation for the Blind. Other organizations and individuals — too numerous to mention — also made constructive suggestions." And further:

"I am authorized to say that the bill has the strong endorsement of the responsible and patriotic American labor leadership, organized in the American Federation of Labor and the Congress of Industrial Organizations; and of the National Farmers' Union. The health provisions of the bill have the endorsement of many persons and organizations working in medical care and related fields. Legislation providing grants for hospital construction has been endorsed by the American Medical Association, the American Hospital Association, the American Public Health Association and various labor, welfare, farm and other public organizations. Most of these organizations are in favor of provisions for additional federal funds for public health and for maternal and child health activities."

It will be remembered that in inquiry from Senator Wagner as to features to be incorporated in this bill the American Hospital Association answered on December 17, 1944:

"To discuss the merits of each of the suggestions in your letter would imply an acceptance of the general principle of legislative compulsion, which the Trustees and House of Delegates of this Association have not endorsed."

In addition to providing compulsory health insurance, the new bill calls for a permanent national system of public employment offices. It extends coverage by the basic social insurance system to about 15 million people now excluded, such as farm workers, domestic employees, employees of non-profit institutions, and to independent farmers, professional persons and small businessmen.

It purposes grants-in-aid to states for public assistance, listing new medical benefits, and including new groups. It provides grants for hospital construction, public health, and maternal and child health services. It adds total disability benefits not now provided under the Social Security Act. Also provided are credits for military service and a federal system of unemployment and disability benefits.

Contributions by employers and employees to provide the benefits would establish a payroll deduction of 4 per cent from the employer and 4 per cent from the employee, as compared with a total 12 percent deduction proposed in the last Wagner-Murray-Dingell Bill. The allocation of these deductions to various benefits is shown in an accompanying table.

Arguments for Reduction

The reduction from 12 to 8 per cent is justified by its sponsors in two ways. First, the original bill specified a 4 per cent deduction for

* Originally published in *Hospitals,* July, 1945.

unemployment insurance. Large reserves having accumulated under this rate, the sponsors now believe that a 2 per cent deduction will be sufficient.

Second, the proposed contribution for combined retirement, survivors' and total disability benefits has been reduced from 4 to 2 per cent. Here the sponsors do not contend that 2 per cent will be adequate. Citing the refusal of the Congress to increase the current 2 per cent, they suggest that the additional cost of future benefits should be met out of general funds of the federal government. It is pointed out that the enactment of this legislation would involve a tripartite system of financing, a portion each by employer, employee and the federal government. This is a very significant change from earlier proposals.

A major provision in the new bill is the granting of medical benefits to the needy. Grants-in-aid are provided to help those states that include such benefits in their plans for assistance. This provision is under Section 6 of the bill, amending the Social Security Act by inserting at the end thereof a new Title XIII—comprehensive public assistance program. The medical benefits seem close to the program of grants-in-aid which has been supported by the House of Delegates of the American Hospital Association.

The bill provides (Section 9) that Title II of the Social Security Act, as amended, shall be further amended to provide for prepaid personal health service insurance. This is the portion of the original Wagner-Murray-Dingell Bill that received so much criticism from those in the health field.

As Senator Wagner indicated in his correspondence with the American Hospital Association last December, the criticisms of the previous bill called for amendments, and a careful reading of the new bill shows that an effort has been made to meet those criticisms. There is a national advisory medical policy committee that can appoint state and local committees to advise in administration of the act. The surgeon general of the U. S. Public Health Service is to work with state and local agencies and appoint local area committees to aid in the administration of this part of the act. The surgeon general, rather than having the ultimate authority, shall act under the supervision and direction of the federal security administrator.

Dental and nursing benefits have been included in the health benefits, a limitation being imposed as to the amount of such benefits, it being required that the ultimate scope of benefits should be based on the funds available and experience as to cost.

Would Increase Payment

Payment to hospitals has been increased to a range of from $3.00 to $7.00 a day for the first 30 days, from $1.50 to $4.50 for periods of hospitalization in excess of 30 days, and from $1.50 to $4.50 for each day of care in an institution for the chronic sick. The surgeon general is given authority to enter into contracts with participating hospitals for the payment of cost of service.

It is provided in the act that "such payment (by the federal government) shall not affect the right of participating hospitals to require payment from patients with respect to the additional cost of more expensive facilities furnished for lack of ward facilities, or incurred at the request of the patient, or with respect to services not included within a contract."

Senator Wagner in introducing this new bill stated: "Propagandists against health insurance shout 'regimentation' of doctors and patients; 'lowered standards,' 'political' and 'socialized' medicine, etc."

The American Hospital Association opposed the original Wagner-Murray-Dingell Bill, believing that compulsory federal health insurance would lead to regimentation, would be difficult to administer without political interference and would not encourage the same rapid improvement in standards of care that has been true in the past.

Former Perils Remain

Careful reading of the bill gives no indication that such perils and difficulties would be removed by passage of this new legislation. Those factors which now prevent ideal results —matters of concern to the medical profession and to hospital administrators — will not be eliminated by transferring authority to a federal agency, no matter how federal authority may be conditioned by advisory councils, federal and local, and by sharing some small amount of the federal administrative power with local agencies.

Section 9 of the bill, amending Title II of the Social Security Act, "Section 205 'Methods and Policies for Administration'" under the prepaid personal health insurance services, graphically portrays the magnitude of administrative problems laid on the surgeon general's desk. This section:

1. Calls for a listing of physicians, dentists and nurses qualified to furnish services.

2. States that individuals may select any from among the professional individuals so designated.

3. Provides that the surgeon general shall designate those physicians who shall be specialists.

4. Defines when consultation or specialists' services shall be available.

5. Provides that the list of practitioners and specialists shall be published.

6. Provides the methods of payment for general practitioners and for specialists on a fee basis, on a per capita basis, or on a salary basis, or a combination of the three; AND it provides that if the majority of practitioners in an area vote for one method the surgeon general may approve some other method for the minority.

7. Provides that the surgeon general shall prescribe the limits of the number of beneficiaries for whom a practitioner or group shall furnish service and other major details, including the following description of responsibilities of the surgeon general which is indicative of the problems that would have to be solved by him as administrator:

"(f) The methods of administration, including the methods of making payments to practitioners, shall (1) insure the prompt and efficient care of individuals entitled to personal health service benefits; (2) promote personal relationships between physician and patient; (3) provide professional and financial incentives for the professional advancement of practitioners and encourage high standards in the quality of services furnished as benefits under this part through the adequacy of payments to practitioners, assistance in their use of opportunities for postgraduate study, coördination among the services furnished by general or family practitioners, specialists and consultants, laboratory, and other auxiliary services, coordination among the services furnished by practitioners, hospitals, public health centers, education, research, and other institutions, and between preventive and curative services, and otherwise; (4) aid in the prevention of disease, disability and premature death; and (5) insure the provision of adequate service with the greatest economy consistent with high standards of quality."

Long Road Ahead

There are those who will read these idealistic instructions in the Wagner-Murray-Dingell Bill and assume that because they are included in the act these aims will be accomplished if authority is given to the federal government. Many people have worked for many years to accomplish these aims and the road is long, crooked and steep. Those who understand the problems will never believe that these aims can be accomplished by federal legislation without regimentation.

This is particularly so when it is borne in mind that almost immediately on passage of the act, these decisions must be made and the program put in operation whether the decisions be right or wrong. Further, they will believe that such responsibility must inevitably be politically

Proposed Social Insurance Contributions
Under the New Wagner-Murray-Dingell Bill

Program	*Employer*	*Employee*	*Total*
Retirement, survivors and extended disability insurance	1.0%	1.0%	2.0%
Medical care and hospitalization insurance	1.5%	1.5%	3.0%
Unemployment insurance	1.0%	1.0%	2.0%
Temporary disability insurance	0.5%	0.5%	1.0%
Total Contributions	4.0%	4.0%	8.0%

directed to the detriment of the present quality of care to patients.

The American Hospital Association is concerned with the improvement of health care in this country, and with making that care readily available to all people. However, this Association will hardly subscribe to legislation, no matter how altruistic may be the aims of its sponsors, if the Association is unable to support the legislation actively on the basis that it will improve hospital care.

Rather than presenting to the layman an omnibus measure which promises more than can be delivered, the Association program (grants-in-aid for hospital construction and grants-in-aid for medical care for the needy and active support of voluntary prepayment hospital and medical care) seems even more logically to lead toward a goal within practical reach for the improvement of distribution of care for the people of this country.

This program may be less dramatic politically, but since improvement in care is the aim of the proponents of this new bill, it will be of interest to see whether the parts of the omnibus measure that are generally recognized as valuable will be held up, or whether the sponsors of this legislation will support them to the end that Congress may enact a health program that is both acceptable to the country and within the ability of the country to finance.

Status of Hospital Construction Bill

Since the new Wagner-Murray-Dingell Bill embodies under Title VI an amended version of S. 191 (also known as the Hospital Survey and Construction Act and the Hill-Burton Bill), the probable fate of this measure is of considerable interest.

S. 191 was introduced last January 10, and hearings on it were conducted by the Senate Subcommittee on Education and Labor. The chairman of this subcommittee is Senator Murray. While all who testified on S. 191 supported it in substance, a number of changes in detail were suggested, and nearly all these changes are found in Title VI of the Wagner-Murray-Dingell Bill.

At the time of writing Senator Murray's committee had not reported S. 191 to the floor, but was expected to do so momentarily, and it was expected that Senator Murray would propose such changes as already are found in the new Wagner-Murray-Dingell Bill, of which he is co-author.

Two Measures Offered

Thus Congress is now confronted with two measures calling for hospital survey and construction, one of them a bill aimed at this alone and the other an omnibus social security bill in which this is relatively a small island surrounded by an ocean of controversial matter.

There has been no statement by any member of Congress as to the relationship between these two pieces of legislation. It is believed that the Senate will continue its consideration of S. 191 and that this widely supported bill may be passed while controversial features of the omnibus measure are under deliberation.

A comparison of the hospital survey and construction features of the new omnibus measure with S. 191 as introduced by Senators Hill and Burton shows a number of significant changes.

The authority of the Federal Advisory Council has been changed from that of an approval body jointly with the surgeon general to a body having only advisory responsibilities. This weakening of the power of the advisory council has been compensated for in part by adding a provision that the surgeon general's annual report shall include a report on consultations with the advisory council, together with the council's recommendations and comments.

This would insure wide publicity for the deliberations of the Federal Advisory Council and would certainly place responsibility on the surgeon general for a careful accounting, should he fail to follow the advice of the council. Whatever the status of the council, this provision for written annual reports would undoubtedly be wise.

The American Hospital Association, the American Medical Association and the National Grange emphasized in their testimony the importance of granting authority on broad matters of policy to the Federal Advisory Council. Hospital people are apprehensive of too much federal authority, even in a hospital

construction bill. President Donald C. Smelzer, in his testimony, indicated that support of the bill was predicated on assurance that hospitals would be protected against unreasonable administrative decisions in Washington through the sharing of authority by the council and the surgeon general.

Senator Taft repeatedly expressed his opinion that those who were depending on the council to limit ill-advised administrative assumption of authority were more optimistic than he as to the effectiveness of advisory bodies, regardless of how much authority they might be granted. There is nevertheless a sincere and strong feeling on the part of the Board of Trustees of the American Hospital Association and its Council on Government Relations that the advisory council should consist of technical workers and that it should have the greatest possible authority consistent with proper administration.

Calls for Experience

In the Wagner-Murray-Dingell Bill qualifications for membership of the Federal Advisory Council have been broadened. The opinion of the American Hospital Association, as expressed by its representatives, has been strongly in favor of a majority of the council being those experienced in and representative of hospital, public health and medical care activities. S. 191 provides for broad representation of the public in the state advisory councils. Decisions to be made on the federal level, however, would be primarily technical and the federal council would be a group of nine individuals with wide powers on important technical matters. The Association would be against so reducing the technical component of the committee as to prevent proper decisions of a technical nature.

Careful thought was given to authority granted the Federal Advisory Council in S. 191. It is evident that those who drafted the bill intended that the council be composed of individuals actively engaged in fields of hospital administration, public health and medical care, and that their contribution would be in proportion to their other responsibilities, and to their experience in these fields.

It is obvious that to insure the functioning of this council, made up of individuals with such experience, their deliberations should be limited to a consideration of broad matters of general policy rather than administrative details. For this reason, the federal council would approve standards for state plans and standards for determining the need for hospital construction, and would approve over-all plans as developed by each state. The council therefore was not to be asked to approve the requests of individual hospitals for construction grants. Not that such approval would not be wise if time permitted; but in order that the council might, in the limited time during which it might be in session, devote its attention to matters of policy rather than to matters of administrative detail.

The Wagner-Murray-Dingell Bill adds tremendously to the detail that is to be submitted to the federal council, asking that each project be passed upon. This addition to a large mass of administrative detail could destroy the value of the council by the very volume assigned for study. The Association is therefore against this change.

Would Limit Appropriations

Another proposed change calls for a 10-year limitation on appropriations, holding these to $50 million for the first year, and $100 million thereafter. Another provides supplemental loans as well as grant. Another provides a recapture provision should the hospital be sold or diverted to other purposes. Still another provides prevailing wage standards be made applicable to aided projects. These all appear to be matters of wide social interest which Congress will consider and which are perhaps not for hospital people to decide.

If the Senate Committee on Education and Labor recommends the Hospital Survey and Construction Act for early passage by the Senate, it is hoped that no changes will be proposed which might prevent continued support by those who are experienced in the health field.

Presidential Address—Continued from page 150

the skill and care it has voluntarily given to care for individual soldier, sailor, and Marine.

In the light of these encomiums the charge of inadequate medical and nursing care falls flat into the arms of the political opportunist who first coined the evil phrase for his own nefarious purposes.

In the future, as in the past, the average citizen will be far better cared for medically than legally, culturally, spiritually, or politically.

Hospitals Now . . . And Tomorrow

By A. C. Bachmeyer, M. D., Director of Study, Commission on Hospital Care

Lack of incentive for young doctors to begin practicing in rural and semi-rural areas is one of the big problems which both the public and the medical groups are facing today. Large hospitals, medical centers and city practices attract many young physicians because of the well-equipped laboratories, skilled technicians and opportunity for continued study.

In vast stretches of rural America there are no hospitals and the small number of physicians which serve those areas must work without the valuable equipment and assistance which a hospital affords.

The nation's post-war planning on local, state and national levels is working toward construction of hospitals to serve those neglected areas. But before any real planning can be done it is first necessary to know exactly what hospital facilities and services are available at the present time.

So last fall the Commission on Hospital Care was established through the efforts of the American Hospital Association and was given the job of taking the vital inventory of the nation's hospital facilities. The Commission on Hospital Care is located at 22 East Division Street, Chicago 10, Illinois.

It is an impartial, fact-finding body and its members are outstanding men and women of national repute who have a sincere interest in public welfare. They include members of the medical, dental and nursing professions; hospital trustees and administrators; public health; medical education; industry; labor; agriculture; public welfare and the fields of sociology and economics.

The work is financed by grants from the Commonwealth Fund, the W. K. Kellogg Foundation and the National Foundation for Infantile Paralysis.

The objectives of the Commission on Hospital Care are to take a census of the present hospital and public health facilities in the nation; appraise their capacity for service; establish standards for evaluating physical facilities, organization and management of hospitals; determine the over-all national need for additional facilities and service; formulate a national coordinated hospital plan and to suggest methods by which that plan can be realized.

National interest in the survey is widespread. Thirty-five states are in one phase or another of their studies. Surveys are in process or about to start in: Iowa, Massachusetts, Michigan, Minnesota, Missouri, North Dakota, New Hampshire and Wisconsin. Survey legislation has been enacted but surveys are not yet started in: Delaware, Indiana, Maine, North Carolina, New Mexico, Oklahoma, Oregon, Rhode Island, Virginia, Vermont and Washington. Survey legislation is pending in: California, Florida and South Carolina. Survey organizing committees have been established in: Illinois, Kansas, Kentucky, Louisiana, Montana, Nebraska, Ohio, Pennsylvania, Tennessee, Texas, and West Virginia. States which are proposing that the Post-War Planning Commission conduct the survey are: Alabama and New Jersey. States which have made preliminary hospital studies are: Georgia, Maryland and Utah.

The commission is conducting a pilot-study in Michigan. The inventory of Michigan's 700 hospitals, including nursing homes and other institutions for the care of the sick is now nearly completed. The method used in Michigan will serve as a pattern which other states may use in making their surveys if they so desire.

A detailed study of every hospital in the entire country would take more time and money than the Commission has at its disposal. Therefore, each state is being urged to carry on its own study. In this manner, local interest in the problem will be aroused. Each state will become immediately aware of its needs and a desire to furnish adequate hospital service will be stimulated. It is suggested that the survey be conducted by a single designated state agency in close coöperation with the state planning commission and the health department. Representatives of medical, dental and nursing professions, hospital administrators, labor, indus-

try, agriculture, public health and welfare should be represented on each state study committee.

Although each state carries on its own study, The Commission on Hospital Care will act as a coördinating body and furnish a standard questionnaire for use by all states making the survey. Other work materials, as well as the aid of technical consultants, will be provided by the Commission. The final job of tabulating the information will be done by the Commission staff in the national office.

The hospital and the private physician are a team against sickness and disease. For a long time physicians and hospitals have worked together—and fought together—to preserve life and health. The technological advances of medicine have made that teamwork more vital and more effective than ever before.

Now that the health spotlight has swung to the hospital, we are becoming increasingly aware that there are not enough hospitals to serve everyone who needs hospital care.

But the spotlight has also swung to *planning*. Before we build, we have to *plan* so that every area—rich or poor—will have its share of the vital hospital facilities.

That is why the Commission on Hospital Care is directing this county-by-county survey of the nation's hospitals. In this way we can put a magnifying glass to the hospital problem in each area, yet retain a picture of the overall needs of the county, the state and the nation.

It is part of the Commission's undertaking to solve the problem of uneven distribution of hospitals and physicians. We know that doctors are not attracted to areas where there are no facilities. So we must be certain that the post-war hospitals are built in the right places. Each community can't just "up — and build a hospital" but must fit itself into the plans of its neighbors.

For all of these reasons, a survey to determine need is vital. The Commission on Hospital Care urges all members of the medical profession and all other public-spirited citizens to give their utmost coöperation to this inventory in order that our nation's hospitals may be built where they are needed and where they can be operated to the best advantage of all of the people.

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Belfast	Waldo County	2nd Friday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Lewiston	Central Maine General St. Mary's General	1st Monday 2nd Monday
Portland	Maine General Mercy	2nd Friday 3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters Thayer	2nd Tuesday Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

The President's Page

To the Members of the Maine Medical Association:

For the past year much has been said about the possible re-opening of our Maine Medical School. It is rather obvious and patent that we have suffered from the loss of the old school which closed its doors twenty-five years ago. It was a sorry day for Maine Medicine when this tragic event took place. The diminution in the number of medical men in our rural districts is easily traced to this happening.

In Vermont where a medical school still flourishes, we find that today 75 per cent of the physicians of that State are supplied by graduates of her own institution, and 85 to 90 per cent of the student enrollment in this school are Vermonters. For a hundred years we had a similar picture in Maine when our medical school graduated Maine boys who went into practice in this State, and the present-day solution of obtaining doctors for Maine is for us to again produce our own graduates.

Some will argue that the re-opening of our school for medical teaching will not meet the present-day needs,—for it is said that times have changed, and with the higher requirements for such education, we could not expect our graduates to go back to rural and small town practice. It is simply propaganda and selfish thought that allow for such argument. We need a Medical School in Maine!

Unknown to many of you, much preliminary planning has taken place, and a small band of interested physicians in our Association has busied itself to the extent that now we may honestly report real progress towards the fruition of our desires.

This subject will be discussed during the winter at the various County Medical Society meetings. Won't you interest yourself, individually, to the extent of giving it wholehearted support and consideration, for with such coöperation and coördination of effort, we certainly can make this a reality and be assured of success?

The subjects of the medical school rebirth, medical insurance and important legislative needs will allow for interesting and valuable discussion in the months preceding our Annual Meeting at Poland Spring next June.

Adam P. Leighton, M. D.,
President, Maine Medical Association.

Editorial

War Ends With Many Problems Still Facing American Medicine

"War's end finds many, many questions of vital interest to American medicine as yet unsettled," says the August 25 issue of *The Journal of the American Medical Association. The Journal's* editorial follows:

"Suddenly the war ended. Men and women were mostly jubilant; some sorrowful; some even apathetic, with a feeling of exhaustion. The control over gasoline was removed; almost immediately roads were overwhelmed with traffic. Along the curbs stood motor cars with tires that burst or springs that cracked or engines that stuck — reminders that motoring will have to await a return to normalcy. So also with human beings — the stresses and strains of the war reveal themselves in a variety of inadequacies — combat neurosis was not limited to the military services.

"The end of the war in Europe brought to the headquarters of the American Medical Association a veritable deluge of letters from medical officers urging that steps be taken at once to insure their instant separation from the service. Occasionally a wife wrote saying, "You got my husband into this; now you get him out!" . . .

"The wounded are still coming home. For maximum recovery the armed forces carry the wounded to centers where they receive the attention of specialists. The Army Medical Department has already indicated that replacements for what the Army calls 'scarce specialists' are not available.

"War's end finds many, many questions of vital interest to American medicine as yet unsettled. The supply of medical and premedical students; the disposal of Army and Navy surplus medical supplies; a proper organization and system for medical services to veterans; the maintenance of intensified, coördinated research; the redistribution and relocation of returning medical officers; the provision of adequate numbers of residencies in the specialties; the development of medical care in the areas of occupation; the reestablishment of interchange of medical information throughout the world— these are but a few of the many problems that demand prompt consideration, careful planning, possible solution.

"Much proposed legislation affecting medical care in postwar America is already before the Congress. New measures tremble in the minds of Senators and Congressmen and in the thoughts of personnel in governmental agencies who seek new fields to conquer. The Office of Defense Transportation relaxed to the extent of permitting groups of 150 individuals to attend conventions. Such relaxation does not, however, permit the assembling of the House of Delegates of the American Medical Association. Yet an early meeting of this body is desirable so that the policies of the Association regarding many problems may be established through its democratically selected official group.

"These are truly, even as in war, times that try men's souls. Scientifically minded physicians will realize that now, even as in war, haste must be made slowly. With sympathetic understanding, with the determination to see the job through to its fortunate happy ending, with the resolve to sink individual desires just a little more for the common good, let us practice more forbearance, so that our world may be that much sooner again a well ordered civilization."

1946 Annual Session to be Held at the Poland Spring House

The council of the Maine Medical Association, in session August 5, 1945, at Augusta, Maine, voted to hold the 1946 annual session of the Association at the Poland Spring House, Poland Spring, Maine, on Sunday, Monday, and Tuesday, June 23, 24, and 25, 1946.

Ralf S. Martin, M. D., of Portland, Maine, Chairman of the Scientific Committee will be in charge of arrangements for the Scientific Program.

Necrologies

George Hudson Ebbett, B. Sc., M. D., C. M. Capt. M. C. U. S. A.
1909-1945

Death came to this young officer, tragically and suddenly, as the result of severe burns and pulmonary complications suffered from a fire at his home near Westover Field, Massachusetts, where he was on duty as assistant chief of the orthopedic service at the base hospital. One of the first physicians of Aroostook County, and the first in Houlton, to offer his services to his country, the death of this young physician brings a sense of personal loss to the community in which he grew up as a young man and had just commenced his life's work in addition to the tragic end of what promised to be a useful and promising career in his chosen profession.

George Ebbett was born in Hodgdon, Maine, on July 21, 1909, the son of Dr. P. L. B. and Luella Green Ebbett. After completing his preparatory work in the schools of Hodgdon and Houlton, he spent two years respectively at the University of Pennsylvania and the University of New Brunswick at Fredericton. He then entered the combined pre-medical and medical course of study at McGill University and graduated in 1936 with the degrees of B. S., M. D. and C. M. Following his graduation he was appointed to the interne staff of the Monmouth Memorial Hospital at Long Branch, New Jersey, and in the fall of 1938 returned to Houlton where he became associated with his father until 1941 when he was ordered to active service in the U. S. Army with the rank of Lieutenant. His first assignment was at Fort Benning, Georgia, which was followed by duties in various training centers in the United States. In August, 1943, he went overseas and was recalled to the United States in 1944 when he was assigned to the orthopedic service in the hospital at Westover Field. On March 21, 1941, he was married to Margaret Louise Barnes of Houlton, who survives him with one daughter, in addition to his father and mother and a sister, Mrs. Harry H. Baulch, wife of Lt. Com. Baulch of the USN.

William Harold Parsons, M. D.
1861-1945

This man was the much beloved physician of the people of Lincoln County for fifty-seven years! Modesty, selfless devotion to duty, unusual diagnostic acumen, lofty principles of personal relationships directed the useful lift of William Harold Parsons. Too much occupied with the service of afflicted humanity he toiled happily in his own field and became known to relatively few of his colleagues throughout the state. Dr. Parsons, the son of Dr. Charles A. Parsons, was born in Buckfield, Maine, in 1861. Graduating in medicine from the University of Vermont, he began practice in Damariscotta in 1885, marrying Anne Glidden Metcalf of that town the same year. Several years of post-graduate study were enjoyed at the New York Post-Graduate Hospital preparing him to render surgical therapy skillfully in those days when life-saving procedures must needs be summarily performed with meager equipment in remote country farm houses. Primarily a physician, he loved surgery and was endowed with natural dexterity and a rare judgement which determined his great success in the field of abnormal obstetrics often under most primitive circumstances. Dr. Parsons was awarded the Fifty-Year Medal by the Maine Medical Association several years before his retirement from practice. William Harold Parsons died June 8th in Damariscotta after a two-year illness. He is survived by his widow and several nephews and nieces.

C. H. J.

COUNTY SOCIETIES

Androscoggin
President, Romeo A. Beliveau, M. D., Lewiston
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Fort Fairfield

Cumberland
President, Henry P. Johnson, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Francis A. Winchenbach, M. D., Bath
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Hancock

The Hancock County Medical Society held a regular meeting at The Hancock House, Ellsworth, Maine, Wednesday evening, August 22, 1945.

Albert S. Crawford, M. D., Neurosurgeon at the Henry Ford Hospital, Detroit, Michigan, was the guest speaker. Doctor Crawford's subject was *General Neurosurgical Problems.*

Carl H. Stevens, M. D., of Belfast, was a guest at this meeting.

J. H. Crowe, M. D.,
Secretary.

Piscataquis

A mid-summer special meeting was held by the Piscataquis County Medical Association at Squaw Mountain Inn, August 2, 1945. Thirty members and guests were present which is a creditable number considering the scarcity of doctors and the rush of work.

F. J. Pritham, M. D., served as President, pro tem.

After the dinner, Roscoe L. Mitchell, M. D., State Director of the Bureau of Health, spoke on recent and proposed medical legislation and a general discussion followed.

The next meeting is to be held at the office of S. M. Marsh, M. D., in Guilford, Thursday, September 20, 1945.

H. C. Bundy, M. D.,
Secretary.

Notice

State of Maine
Board of Registration of Medicine

Adam P. Leighton, M. D., Portland, Secretary.

List of Physicians Licensed in Maine, July 11, 1945.

Through Examinations

George Otis Cummings, Jr., M. D., Deering Street, Portland, Maine.

John L. Doherty, M. D., 270 Commonwealth Ave., Boston 16, Mass.

Anna Platt, M. D., "Greystones", Friendship, Maine.

Through Reciprocity

Richard A. Bloomfield, M. D., The Haven's Inn, North Haven, Maine.

Amy Louisa Cattley (Rock), M. D., 353 E. 53rd Street, New York, N. Y.

Marguerite Louise McKay Dwyer, M. D., 243 Main Street, Bar Harbor, Maine.

Irving I. Goodof, M. D., 750 Harrison Ave., Boston 18, Mass.

Daniel A. Rock, M. D., 353 East 53rd Street, New York, N. Y.

Proceedings

Maine Medical Association

HOUSE OF DELEGATES

AUGUSTA, MAINE

JUNE 24, 1945

FIRST MEETING OF THE HOUSE OF DELEGATES, JUNE 24, 1945

The House of Delegates of the Maine Medical Association convened at the Augusta House, Augusta, Maine, on June 24, 1945, at eleven o'clock in the forenoon, with Adam P. Leighton, M. D., of Portland, President-elect, presiding.

CHAIRMAN LEIGHTON: The meeting of the House of Delegates will please come to order. First, I shall ask for a roll call by the Secretary.

(Frederick R. Carter, M. D., of Portland, called the roll and twenty-three delegates responded.)

CHAIRMAN LEIGHTON: As we have many more than the required ten for a quorum for the transaction of business, we shall proceed.

At this time, I shall name the Nominating Committee, one delegate from each District. First District, Francis J. Welch; Second District, Garfield G. Defoe; Third District, C. Harold Jameson; Fourth District, Clarence R. McLaughlin; Fifth District, James H. Crowe; Sixth District, Martyn A. Vickers. Dr. Welch to be the Chairman. This Committee will report this afternoon at the meeting at 4:30.

The report of the Council for 1944-1945 will be heard at this time, and I shall ask the Chairman of the Council, Dr. E. Eugene Holt to give us this report.

(Dr. Holt then read the report of the Council for 1944-1945. This report is on file in the Association Office at Portland.)

CHAIRMAN LEIGHTON: You have heard the report of the Chairman of the Council. What is your pleasure?

A MEMBER: I move the acceptance of the report of the Council, by Dr. Holt.

This motion was duly seconded and was carried.

CHAIRMAN LEIGHTON: For the Reference Committee, I appoint Drs. Waldo T. Skillin, James H. MacDonald and Forrest B. Ames.

The next order of business is the presentation of the budget for 1945-1946, as recommended by the Council, and I shall ask Dr. Carter to give you that report.

SECRETARY CARTER: The Council, in session this morning, voted that the following Budget for 1945-1946, be approved for presentation at the First Meeting of the House of Delegates:

President's Expenses,	$ 300.00
Salaries:	
Secretary-Treasurer-Editor,	2,200.00
Assistant Secretary,	2,000.00
Office Expenses,	1,000.00
Committees:	
Medical Advisory,	500.00
Graduate Education,	100.00
Special,	100.00
State Delegates and Council,	250.00
Delegate, A. M. A. Annual Session,	250.00
Annual Session,	100.00
Appropriation to JOURNAL for expenses not covered by advertising,	500.00
Total,	$7,300.00

(On motion, duly seconded, the Budget, as presented by Secretary Carter, was approved by the House of Delegates.)

CHAIRMAN LEIGHTON: Next, I shall ask Dr. John O. Piper, Councilor of the Fourth District, to give us his report.

DR. GEORGE L. PRATT of Farmington, Secretary, Maine Medico-Legal Society: May I have a moment while we are waiting for the Doctor? The Maine Medico-Legal Society's Annual Meeting will consist of an Executive Committee meeting this evening at seven o'clock. If there are any medical examiners present, we should like to have them here, and if we have as many as a dozen, we will have a dinner in a private dining room; if not, we shall have dinner in the main dining room and meet later. I wish to ask all the medical examiners to let me know as soon as possible.

CHAIRMAN LEIGHTON: Dr. Piper has come in. Dr. Piper, will you give us your report as Councilor of the Fourth District.

DR. JOHN O. PIPER of Waterville: Kennebec County: Number of meetings, five; number of new members, none; number of men in the service, 26; no deaths.

Somerset County Medical Society: Number of meetings, none; new members, none; service men, 6; number of deaths, none.

I did not receive the statistics from Dr. Torrey of Waldo County.

CHAIRMAN LEIGHTON: You have heard the report of Dr. Piper as Councilor of the Fourth District. What is your pleasure?

A MEMBER: I move that the report be accepted.

This motion was duly seconded and was carried.

CHAIRMAN LEIGHTON: At this time I am going to skip over to the report of the Committee on Conservation of Vision, and I shall ask Dr. Kershner to step forward and give us his report.

DR. WARREN H. KERSHNER of Bath: Mr. Chairman and Gentlemen. Dr. E. Eugene Holt is Chairman of this Committee, but he has asked me to report for him. We have had three meetings and have gone over the problem.

As you well know, and have seen in the past in the JOURNAL, the major problem at the present time is the glaucoma problem. It may be interesting for you to know that we are in no worse or better shape in this state than the average in the United States.

Their problems are many, and as I have reported at the time I was Chairman of the Committee, it is a long-range program and what is actually accomplished in one year is little. But, I think the ophthalmologists, as a whole, feel that they are getting from the medical men sufficient cases of glaucoma earlier than before this little program was taken up in this State.

There is another factor which we have under consideration and probably will have to come to the Association for assistance and advice, and it is this. The

non-medical men, refractionists, are seeing a good many of these cases, and the most of them are not conscious of the glaucoma problem in any way whatsoever, nor are they trained to recognize it. They do not think in terms of pathology; they think in commercial terms. We feel that sooner or later, something of a similar organization and program should be made up, similar to the tuberculosis program and the present active cancer program. In other words, we believe that some methods should be used to inform the public as well as the general medical men of the problems of glaucoma and what it means in the economic life of our State.

Chairman Leighton: Thank you, Doctor. You have heard the report, Gentlemen. What is your pleasure?

A Member: I move that this report be accepted.

This motion was duly seconded and was carried.

Chairman Leighton: At this time, I will present the report of the Committee on Hospitals and Medical Education.

To render a suitable report for the Committee on Education and Hospitals is again indeed a large order. Conditions have changed little and the report of last year could well be used at this time. Hospitals have their problems, in a greater number perhaps than at any time during this war period. The help question is most bothersome and every department in medical institutions is undermanned. The tremendous increase in admissions to our hospitals, due to the swollen population in communities engaged in war work, plus the opportunity given Blue Cross policy holders, to have hospitalization and medical care, such as never was their fortune previously, has filled the hospitals to capacity. The nursing care for these individuals has been lessened and maybe inadequate, but the help of volunteer workers and nurses' aids has done much to ease the load. Cadet nurses, under Government control and supervision, filled in the ranks, diminished by the taking of graduates into the Armed Forces, and the diminution in the number of young women entering our training schools. The acceleration of courses, in our medical schools, and the shortening of the internships, has made it exceedingly hard for the larger general hospitals to obtain the required number of internes. Much credit is due the Directors and the Trustees of these institutions, for the fact that with all these trials and tribulations, medical care has been offered the public, for the most part, in adequate amount.

The number of physicians presenting themselves to the Maine Board of Registration of Medicine, for registration and licensure, has fallen off considerably. About one-third the usual yearly registration has taken place. Obviously this means lessened medical care for the public at large. Recent graduates are hurriedly commissioned in the Army and Navy and little opportunity is offered them to appear before the State Boards for examination.

Our rural districts have suffered greatly, too, and in many places no medical care is available. Our cities and the larger communities have lost to the Service, most of their young and active practitioners. The Osteopathic Profession, awake and alive to the situation, has "taken over" in great style and made the most of their opportunity. The public has accepted them and makes little effort to discriminate. The Osteopaths hold themselves out, in most instances, as practicing BOTH medicine and osteopathy and with their added rights and privileges of practice, gained through legislation, when we were not alert, they carry on the masquerade. The closing of the Medical School of Maine, twenty-five years ago, was a shameful error and we have lived to see the truth of the statement. The loss of our one hundred year-old school of medicine, is the true etiological factor for the chaos in which Maine medicine finds itself today. One cannot argue against the fact that the old medical school furnished, through its graduates, ample care for the people of Maine and it could do it again, if this institution could but be reborn. It makes no great difference as to where this school might be located,—Portland, Bangor, or Waterville! The opportunity is before us and to save the day we need a school for medical teaching in Maine.

A Committee will be named today to labor and carry on to this end.

Adam P. Leighton, M. D.,
Chairman.
Allan Craig, M. D.

Chairman Leighton: You have heard the report. What is your pleasure?

A Member: I move that the report be accepted.

This motion was duly seconded and was carried.

Chairman Leighton: We shall now listen to the report of the Cancer Committee, which will be read by Dr. Carter.

(Secretary Carter then read the following report as submitted by Julius Gottlieb, M. D., Chairman.)

The various tumor clinics throughout the State of Maine have shown an increased number of patients examined and treated. Their clinics have been held regularly despite the increased volume of work and the increased demands on the various clinic physicians. Gratitude is expressed to the tumor clinic physicians for their devotion to the clinic work and their contribution of time and talent.

In coöperation with the Women's Field Army circular letters and pamphlets have been mailed to each of the physicians in Maine with the view of acquainting the physicians with the various cancer problems and an attempt to standardize methods of procedure in the diagnosis and treatment of tumor patients.

It has been recommended that a program of study be initiated in coöperation with the American Cancer Society involving the follow-up of patients over a period of five to ten years and to review cases treated within the last ten to fifteen years. It has also been suggested that a social worker be employed over a period of time at each of the various clinics gathering the statistical data for purposes of correlation of types of tumors diagnosed, the therapy instituted, and the results obtained. It has been further suggested that a central tumor registry be established and that such a registry be reviewed by the various pathologists throughout the state to further standardize diagnoses and therapy.

Chairman Leighton: You have heard the report of the Cancer Committee, presented by Dr. Carter for Dr. Gottlieb. What is your pleasure?

A Member: I move the acceptance of this report.

This motion was duly seconded and was carried.

Chairman Leighton: For the Financial Advisory Committee, I am now going to call upon Dr. Foster C. Small.

Dr. Foster C. Small of Belfast: Mr. Chairman, and members of the House of Delegates. In my own mind, I sometimes wonder and I think it has been previously discussed, relative to the necessity of this Committee. . . .

Dr. Albert W. Plummer of Lisbon Falls: Now, Mr. Chairman, if it would be in order, I move that a sum not exceeding $10,000, as the Council and the Officers of the Association see fit, be put into United States Government Bonds.

Chairman Leighton: Is that counting the $4,000 already invested in bonds? Do you mean another $6,000?

Dr. Plummer: Well, I said a sum not exceeding $10,000.

Dr. Pratt: As I understand Dr. Plummer's motion, it is left to the discretion of the Council.

Dr. Plummer: Yes, that is right.

Dr. Pratt: If he hadn't meant that, I was going to offer that as an amendment.

Chairman Leighton: I have a report here of the Committee to Investigate Collection Agencies, which I am going to read to you.

The Committee of One whose duty is to investigate the so-called "Collection Agencies," would report that he has diligently attended to these matters and has recommended to the members of the Association, only those where inquiry and personal interrogation as to the business methods and reputation of such organizations, has proven their worth and honesty of purpose.

Your Committee would earnestly advise that it would be well to communicate with the Office of the Maine Medical Association, 142 High Street, Portland, Maine, before entering into any contract or agreement with collectors whom you do not know or whose names are not on the list of approved collection agencies.

Some of the doctors are being "taken in" by glib salesmen and "fly-by-night" collectors. Do not sell your accounts and do not give any person a list of your patients who owe you money, without careful examination of their technic and manner of doing business. It is still a good "racket" in these parts and medical men are known to be trusting and easy, in matters of this sort.

Chairman Leighton: I would say that this matter is really important. It isn't any of my business or any of our business what our friends and colleagues do. But if you knew some of the tragic happenings in the past year, yes, in the past three years, that have come through the medium of collection agencies, you would pass this word along.

We have some collection agencies who would collect your accounts honestly, properly, and the patients would come back to you as they don't get angry. And the agencies will give you an accounting each month and get your money for you. But there are also some beauts flying around here, buying up your accounts and giving you some foolish contracts; then they move out to Philadelphia, Boston, Pittsburgh, and you never see them again. Perhaps some of you know the unfortunate happenings that have been going on here, as the result of doing business with these people.

I advise you to consider, before taking on collection agencies, and find out whether they are honest and reputable. We have a few of them left, and I will give you their names if you want them.

The next report is the Report of the Amy W. Pinkham Fund Committee by Dr. Foster. Dr. Foster is not here at this time. Does anyone wish to report for him? Then I think he will be here later, and he will report later.

Now, is there any comment on the business so far? If not, we will take up new business.

At this time, before the House of Delegates, comes the question as to whether we shall elect a new slate of officers this year or not. As I understand the Constitution and By-laws, I doubt if delegates themselves could do so legally, but we could adjourn, if you saw fit to do that, and we could meet as an organization of medical men of the Maine Medical Association, and do this business properly and legally. Is that right, Doctor?

Secretary Carter: Yes.

Chairman Leighton: I should think that would be the sensible way to do it, as it might be open to some discussion otherwise.

Now, on this question of the election of officers, do you desire to elect a new slate of officers for the next year, or do you not?

Secretary Carter: Mr. Chairman, we were instructed by the Council at the last meeting to send a letter to each of the county secretaries. We sent a letter to the President and the Secretary of each county society, asking them to take the matter up at

their next meeting, or, if there was no meeting, to hold a special meeting so as to instruct delegates how to act. We have heard from six counties. Washington County wants to retain the officers for another year. Cumberland County, Kennebec County, Hancock County and Penobscot County voted to elect a new slate of officers.

Dr. P. L. B. Ebbett of Houlton: Add to that Aroostook.

Secretary Carter: I was at the Oxford County meeting the other night and they voted to send their delegates uninstructed.

Chairman Leighton: From the remarks, it would seem as if the majority of the county societies were in favor of electing officers by the membership, which, of course, is made up of members of the House of Delegates here. Has anybody any further discussion on this subject? If not, is there a motion from the House?

A Member: I move that we proceed to elect a new slate of officers, and that it be done by adjournment, temporarily, of this House of Delegates.

This motion was duly seconded by several of the members present and was carried.

Chairman Leighton: I am going to take this moment, if I may, to appoint a committee. This may seem unnecessary to some of you, but I hope not to all of you. I refer to a Committee to Formulate Plans for the Reopening of the Bowdoin Medical School. I wish to appoint Drs. Eugene E. O'Donnell, Frederick T. Hill, Francis J. Welch, Carl M. Robinson, Allan Woodcock, and perhaps to add my own name. This Committee will meet very shortly, with those who have had some interest in this matter, and I sincerely hope, within the year, before the coming of another meeting, to have something to present to you which will be of intrest.

Dr. Martyn A. Vickers of Bangor: You mentioned that you were interested in opening a medical school, in your introductory remarks, in the State of Maine, and that you didn't care whether it was in Bangor, Waterville or Portland. Why does your committee specifically name Bowdoin?

Chairman Leighton: I should have said "a medical school" because things have happened in the last four or five months which obviously make it necessary to give it another name. Bowdoin College, unfortunately, cannot enter into it. The set-up as tentatively arranged by the Council on Medical Education in Chicago has put an end to any thought of Bowdoin College, evidently. In other words, it can't be a divided school, and there are also other things that enter into it. So I should have said "a Maine medical school." I am glad you called that to my attention.

I see that Dr. Foster has come in. Doctor, will you give us your report of the Amy W. Pinkham Fund Committee?

Dr. Thomas A. Foster of Portland:
Mr. President and Gentlemen:

Dr. Bliss appointed in July, 1944, the following members of the association to serve on the Amy Pinkham Fund Committee:

Virginia C. Hamilton, M. D., Bath; Guy E. Dore, M. D., Guilford; Albert M. Carde, M. D., Milo; Clair S. Bauman, M. D., Waterville; P. L. B. Ebbett, M. D., Houlton; John F. Hanson, M. D., Machias; Thomas A. Foster, M. D., Chairman, Portland.

Allow me to recall to your mind some facts relative to the fund. Amy W. Pinkham left twenty thousand ($20,000) to be used for the benefit of undernourished and tuberculous children of Maine, and in her will, Miss Pinkham requested that the money be intrusted to some established organization in Maine which promoted the welfare and interest of children. The Probate Court Judge of Cumberland County, in interpretation of the testator's wishes, designated the Maine Public Health Association, Incorporated as the proper organization to receive the funds. And the Judge, furthermore, designated the Maine Medical Association, or a committee thereof, to advise the Maine Public Health Association, Incorporated about the expenditure of the funds. In fact, he stipulated that the money should not be spent without the approval of this committee.

To date, the fund has accumulated eight hundred and sixty dollars and fifty-five cents ($860.55). The principle fund is invested in United States Treasury Bonds with the Trust Department of the National Bank of Commerce acting as custodian.

During the past year, your chairman has met with Mr. Frank Mott, the administrator of Miss Pinkham's will, and with Judge Albert J. Stearns, President of the Maine Public Health Association, and with the Executive Committee of the Maine Public Health Association. It has been agreed, as a result of these meetings, that at the present time, no plan should be inaugurated. Therefore, your committee has not been called together this year. The committee, however, is aware of the importance of the fund, and may be counted upon to support a well considered program at a later date.

A Member: I move that we accept the report of Dr. Foster on the Amy W. Pinkham Fund.

This motion was duly seconded and was carried.

Chairman Leighton: Is there any further business to come before the meeting at this time? If not, a motion is in order to adjourn until 4:30 this afternoon.

A Member: I move that we adjourn until 4:30 o'clock this afternoon.

This motion was duly seconded and was carried.

(Whereupon, the first meeting of the House of Delegates was adjourned at 12:10 o'clock noon.)

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, October, 1945 No. 10

*Physicians as Metaphysicians**

Julius Seelye Bixler, Colby College, Lewiston, Maine

I have often wondered whether we have not the right to ask our physicians to take on an added burden in addition to those they are already shouldering so well. Are we not justified in asking them to help us with the problems that our minds as well as our bodies confront? Have they not had experiences which should enable them to solve some of the more knotty problems of thought and could they not pass this experience on to us? In short, should we not ask them to be metaphysicians as well as physicians?

What is a metaphysician? According to William James's definition — and we should recall, perhaps, that in his technical training James was a doctor of medicine, not a doctor of philosophy—a metaphysician is "one who makes an extraordinarily stubborn attempt to think things through consistently." Of course the trouble with most of our metaphysicians is not that they fail in thinking things through according to the light that they have, but that the light they have does not reach far enough. It is because the physician sees so much more of life and its many-sidedness than most people that we feel he ought to have more light on life than do most people. Such a person ought to be able to "think things through" not only in an "extraordinarily stubborn" but in an "extraordinarily successful" way.

Take first of all the fact that the physician is a scientist and not a narrow one but, so to speak, a humane scientist who ought to be able to see in a broad fashion what the possibilities before science really are. Ordinarily we become violently partisan over science and line up in warring camps, one saying; "Look at all the harm it has done," the other: "Look at all the good." In this conflict we often forget to distinguish between science as a body of knowledge and science as a method of inquiry. As a rigorous intellectual method science ought to be able to teach us some of the outstanding moral virtues. It requires not only insight and discrimination, but courage, devotion, disinterestedness, and, perhaps most important of all, coöperativeness of a high order. Further, science in its sphere teaches the same truth that democracy teaches in the field of human relations. Just as democracy takes each person as an end in himself, so science allows each fact to speak for itself and shows no partiality.

* The substance of the Gerrish Lecture, delivered at Central Maine General Hospital, Lewiston, Maine, May 11, 1945.

In *Religio Medici,* Sir Thomas Browne says: "No one should approach the temple of science with the soul of a money-changer." The physician just because he is constantly turning science to human account should understand, better than anyone else, what this saying means. As all of us know, science will dominate in its own way the future life of man on this planet. An important question is therefore whether we shall take science negatively, with its denials, its provincialisms and its limitations (where, for example, it denies knowledge of the higher values because such knowledge is not based on scientific methods), or shall bring out its positive implications for the moral life. If we are to do the latter we need the physician's help.

In the next place, the physician, just because he is both a hard-headed scientist and also a practical helper of mankind appears to have been able to set up professional standards that are remarkably high in their social idealism. We have begun to look to medical men as a group for a professional interest in something besides money-making. We know that they are concerned with the prevention of disease as well as its cure, that they make their discoveries available to all men and do not insist on adequate compensation as their first right, and that "public service" has become for them not an idle phrase but one with practical meaning. They seem in other words to have learned how to find that important middle road between idealism that is too sentimental and practical life that is too selfish. They make a living at their profession but they do not put making a living above all other ends. As Sir William Osler says: "Of course there are Gehazis among us who serve for shekels, whose ears hear only the lowing of the oxen and the jingling of the guineas, but these are exceptions." A profession of which this can be said has much to teach the rest of us!

In the next place, the physician is one who sees life at its times of crisis and should be able to help us to understand what these crises mean and how they ought to affect our thinking. For example, is it not the physician who knows more than anyone else about the influence of mind on body? At last we have a science dealing with this very subject—the science of psychiatry. But am I not right in thinking that as a science it still leaves much to be desired? And may the trouble not lie in the fact that it has copied too slavishly the methods of the experimental sciences that are already on the scene? It appears to me that if psychiatrists would only recognize that their data are not observable as are the data of the physical sciences and that the same kind of experimenting with them cannot be done, their own work would progress more rapidly. They have already revealed certain mechanisms in the human personality that help us to understand it better and to prescribe for it more effectively when it is sick. But the vast and complicated problem of how the mind influences the body will require other methods than those of the experimental sciences if it is to be solved, and it appears to me that psychiatrists are themselves suffering from the "inferiority complex" they talk so much about when they refuse to see that psychiatry, to be most useful, need not be slavishly "scientific" in the older sense. Physicians, in their humane and practical approach to the problem should be able to see what the real possibilities before psychiatry are.

As another example of how the physician may help us to see the larger problem, take the fact of his experience with death. For most of us death is placed at one side as something we think about just as little as possible. The result is that the thought of death hardly enters our philosophy in the creative way it should. Both Plato and Schopenhauer remind us that it is hard to philosophize without philosophizing about death. Says Shelley: "Death has set his hand and seal on all we are and all we feel," and Heidegger tells us that life is essentially that which is lived with death in view so that it is really death that marks out for each life its possibilities in the way of individuality. But by most of us all this is ignored. Could not the physician help us to think about death, not morbidly, of course, nor yet as anything that should take up a disproportionate part of our interest, but as a subject which should influence our views of what we are and what we ought to do?

And might not the same be said of suffering? Hospitals, like cemeteries, we place on one side and refuse to think about any more than we have to. Yet suffering is a most pervasive influence. Life is made up, in much larger part

Continued on page 173

*Intraspinal Myelography and the Herniated Intervertebral Disc in the Lumbar Spine**

By Robert R. Rix, M. D., Manchester, N, H.

One of the great surgical advances of the past decade is the diagnosis and treatment of the herniated or ruptured intervertebral disc. That this condition may cause sciatica by pressure on a nerve root within the lower lumbar spinal canal has been demonstrated countless times by many different operators. The conception that intraspinal compression of a nerve root is the commonest cause of sciatica is winning more and more adherents as time goes on.

A great many investigators have made contributions to the present status of this entity, but a few are especially outstanding. Schmorl[1] was the first to adequately describe the condition from a study of postmortem findings. Mixter and Barr[2] placed the lesion on a firm clinical basis. Hampton, Robinson, and Kubik[3, 4] developed the technique of intraspinal myelography to a point where it became an easy, practicable procedure. And lastly, we are indebted to the Eastman Kodak Company for Pantopaque[5] which is an absolutely safe medium for use in opaque myelography.

It is with the subject of intraspinal myelography that this paper is chiefly concerned. The procedure is so simple, so safe, and so reliable that it should seldom be omitted when any surgical procedure is contemplated on the spinal canal. It is not used primarily for the diagnosis of the ruptured disc. The diagnosis can usually be made by the clinical examination. The value of the myelogram lies in its localization of the lesion. Once accurately localized, the operative removal is greatly facilitated and the least possible tissue is removed in approaching the lesion.

A detailed discussion of the diagnosis of the ruptured disc by clinical examination is beyond the scope of this paper but the salient features are worthy of mention. The history is one of low back pain and sciatica, or either one alone, coming in attacks and extending back over a period of months or years to an injury, often a lifting injury. Physical signs point to the lumbo-sacral region of the spine. Straight leg flexion is limited on one or both sides. Neurological changes may or may not be present in one or both extremities. When present, the neurological signs are often helpful in localizing the lesion but they can be misleading and they are often vague. It is for this reason that the opaque myelogram is so valuable.

Before the myelogram can be correlated with the clinical findings certain anatomical and pathological facts must be appreciated. The vast majority of ruptured discs causing symptoms occur at either the 4th or 5th lumbar interspaces. Since the herniation may be on the right or left or in the mid-line there are, therefore, six common sites. A lateral herniation always compresses the nerve root at the interspace above the foramen by which the nerve leaves the spinal canal. The fifth lumbar nerve is compressed at the 4th lumbar interspace and the 1st sacral nerve at the lumbo-sacral interspace. A nerve root is not compressed in its intervertebral foramen.

For a detailed description of the technique of intraspinal myelography using an opaque medium the reader is referred to the original article by Kubik and Hampton.[4] Three cubic centimeters of the oil is injected into the dural sac at the 3rd lumbar interspace with the patient lying prone on a fluoroscopic tilt table. The oil, being heavier than the spinal fluid, lies on the anterior surface of the canal which is the posterior surface of the vertebral bodies. Any space taking lesion in the spinal canal will indent the column of oil. By tilting the table, the oil is moved up and down the canal and observed under the fluoroscope. The oil is puddled at each interspace and a film is taken. At the conclusion of the examination the oil is removed through the needle which has been left in place for that purpose. If all of the oil can not be recovered, there need be no great con-

* Presented before the York County Medical Society, Saco, Me., April 11, 1945.

cern since the remainder will eventually be absorbed, provided Patopaque has been used.[5]

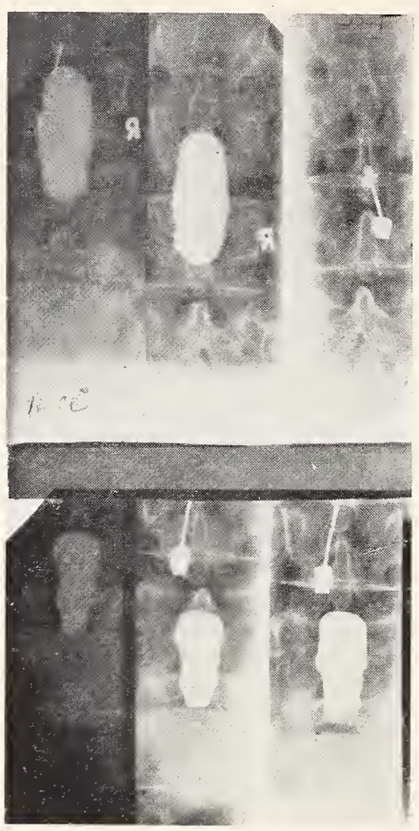


Fig. 1. Normal myelogram. Note that the point of the needle is exactly in the midline. This is essential for removal of the oil.

Fig. 1 is a normal myelogram. The end of the dural sac can be seen at the level of the top of the sacrum. The root sheaths of the 1st sacral and 5th lumbar nerves are well shown. Note the perfect symmetry of the column. One strip of film shows the tiny drop of oil remaining at the point of the needle after the removal of the oil. The whole procedure from the introduction of the needle to the removal of the oil may be easily accomplished in 30-45 minutes.

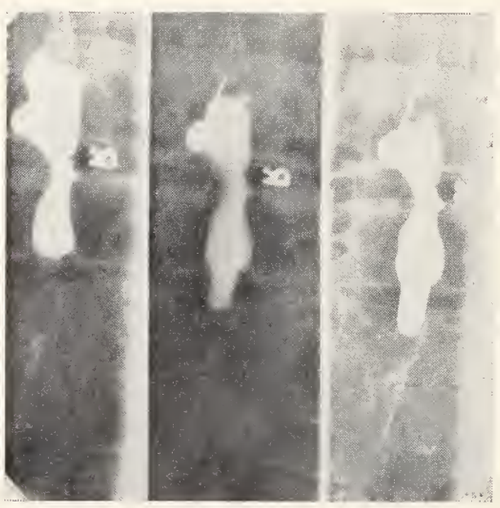


Fig. 2. Myelogram showing large defect on the left at the 4th lumbar interspace.

Fig. 2 shows a fairly large defect on the left side at the 4th lumbar interspace. In comparison, note the symmetry of the 1st sacral nerve root sheaths at the lumbo-sacral interspace. At operation the fifth lumbar nerve was adherent to the herniated nucleus pulposus. The herniated tissue is seen in Fig. 3. It is the large single mass on the left. The small pieces of tissues were removed from the interior of the disc itself.

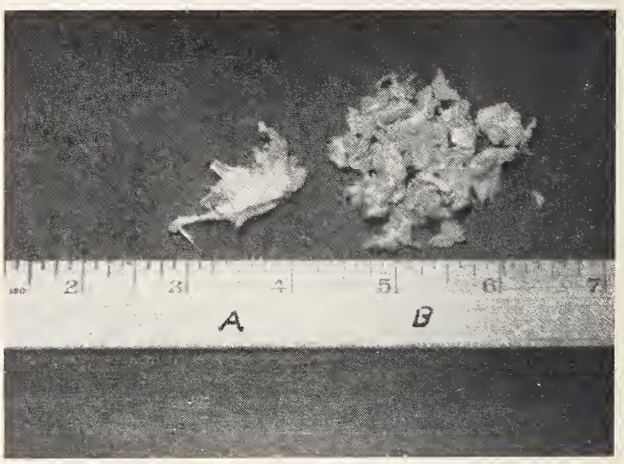


Fig. 3. Herniated nucleus pulposus (A) and disc contents (B) removed from the spine shown in Fig. 2.

Fig. 4 represents a right-sided herniation at the lumbo-sacral disc. A thin disc was also present at this level, and in addition there were neurological changes indicating involvement of the right 1st sacral nerve. A laterally placed protrusion was found at operation.

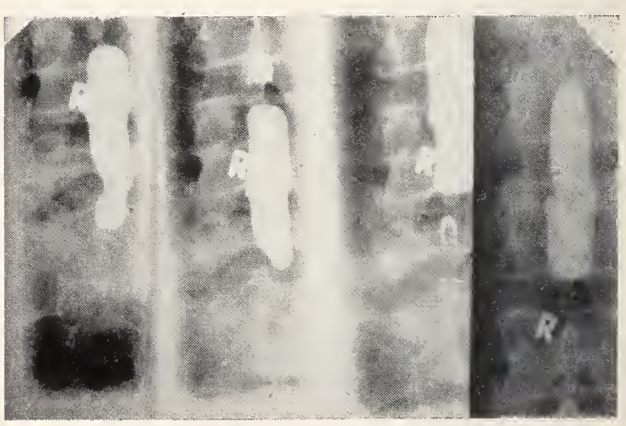


Fig. 4. Myelogram showing obliteration of the 1st sacral nerve root sheath together with a moderate-sized defect on the right at the lumbo-sacral interspace.

In both the foregoing cases, sciatica was the leading symptom. Fig. 5 is the myelogram of a patient in whom the only complaint was low back pain. The diagnosis was made by reason of the marked limitation in straight leg flexion bilaterally. The myelogram shows a midline lesion at the lumbo-sacral disc slightly more on the right side. Obviously a myelogram was indispensable in this case. Since the protrusion was slightly to the right of the midline it was approached from that side by retracting the 1st sacral nerve root and dural sac to the left. A detail like this is of great assistance to the operator.

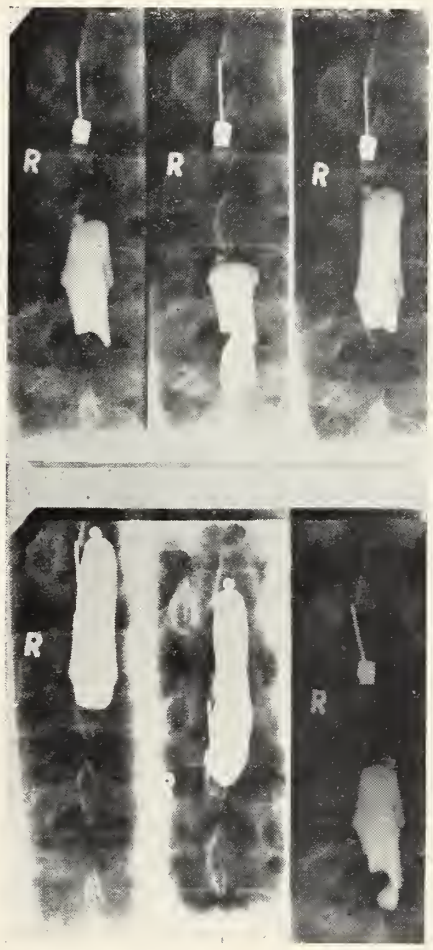


Fig. 5. Myelogram showing a well marked defect slightly to the right of the midline at the lumbo-sacral disc. Note that the point of the needle is off center. The needle had to be reinserted before the oil could be removed.

Fig. 6 shows the spine of a patient who had such excruciating pain that the prone position could not be assumed for the myelography. Note that the 4th lumbar interspace is definitely thinner than the 3rd. This fact combined with clear cut neurological changes indicating the right 5th lumbar nerve were sufficient for localization. Two large free fragments of annulus

Fig. 6. Thinning of the 4th lumbar disc as compared to the 3rd lumbar.

fibrosus and herniated nucleus pulposus were removed and are shown in Fig. 7. The small pieces are disc contents. In this case a myelogram would have made the operation much easier since the larger of the two fragments was in the midline and was almost missed. In fact, the presence and shape of the defect in the myelogram adds greatly to the surgeon's ease of mind and facilitates the work in every way. It may be added that the test is also of value in differentiating the cauda equinal tumors from the ruptured discs.

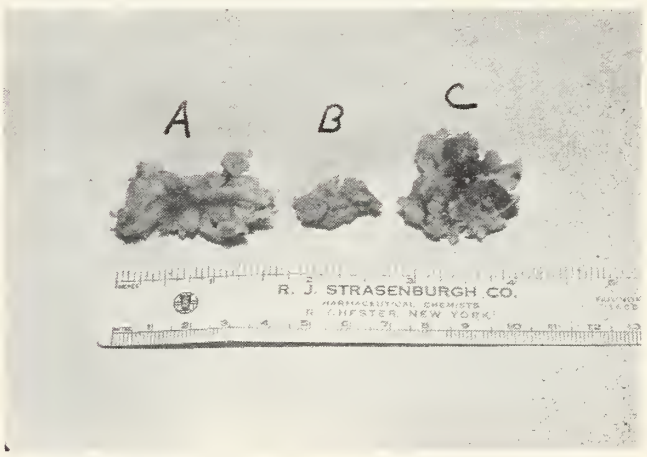


Fig. 7. A large, free fragment of annulus fibrosus (A), a piece of herniated nucleus pulposus (B) and disc contents (C) removed from the spine shown in Fig. 6.

Fig. 8 shows a complete obstruction at the lumbo-sacral interspace. Note the complete absence of both the 1st sacral nerve root sheaths

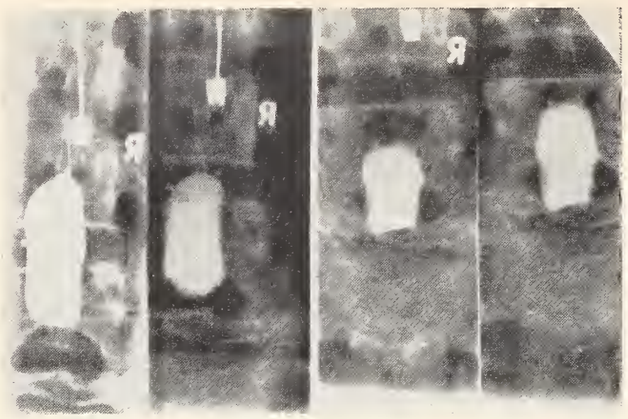


Fig. 8. Myelogram showing a complete block at lumbo-sacral disc in a spondylolisthesis, Fig. 9.

as well as the terminal dural sac. This was in a case of spondylolisthesis, Fig. 9, with well marked neurological changes indicating a compression of the entire cauda equina. From the myelogram a large midline herniation of the disc was suspected but at operation the obstruction was found to be due to compression of the dural sac between the fifth lumbar lamina posteriorly and the body of the sacrum anteriorly. The nerve roots of the cauda equina were matted together due to the long standing irritation and thus the complete block was produced. A small herniation of the nucleus pulposus was also present on the right side. A laminectomy completely decompressed the cauda equina.

Fig. 9. Spondylolisthesis. The 5th lumbar vertebra has slipped forward approximately ¼ inch on the sacrum. The film has been retouched for the sake of clarity.

There are certain pitfalls in the interpretation of myelograms. The test is more reliable at the 4th and 5th interspaces than it is at the interspaces above. A narrowing or hourglass constriction of the column of oil at the 2nd and 3rd interspaces as seen in Fig. 10 is not uncommon. Notice how the oil has been separated into two puddles by the 3rd lumbar disc. This appearance is due to the posterior prominence of the discs at these levels and not to any herniation. The fact that the anterior surface of the lumbar spinal canal is more concave in its lower than in its upper portion is also a factor in producing these defects which are without clinical significance.

Fig. 10. Myelogram showing hour-glass constriction and separation of the column of oil into puddles at the 2nd and 3rd lumbar interspaces. (The faint lettering, (5L, 1S, etc.) refers to the nerve root and not to the vertebra.)

The operation itself, though essentially a neurosurgical procedure, is not difficult for the orthopaedic surgeon who is familiar with the technique of operating on the spine. The Hibbs type of spine fusion is excellent training for the operation as it is performed today. The approach is made through the interlaminal space and very little bone is sacrificed. The structural integrity of the spine is preserved. The dura is not opened and, therefore, the risk of meningitis as a complication is nil. The operation may be performed in an hour and a half or even less. The convalescence is comparable to that following an interval appendectomy. The patients may be allowed up somewhere between the 7th and 12th day according to the discretion of the surgeon. Some type of spinal support is appreciated by the patients for 6 to 8 weeks post-

operatively. The results in most cases are very gratifying.[6] The occasional patient is not immediately relieved and in these cases it is believed that the nerve becomes involved in the scar of the healing process.

The author never combines the operation for removal of a disc with a spine fusion. To do a thorough spine fusion after removal of the ligamentum flavum is difficult and prolongs the operation a good deal. Also it destroys one of the great advantages of the disc operation, namely, short convalescence. Furthermore either one operation or the other is indicated in each case. Here again the myelogram is of great value in determining which procedure to use.

Summary

Intraspinal myelography using an opaque medium should be used in every case of suspected herniated intervertebral disc in which operative removal is contemplated. It is a simple, safe, and reliable procedure.

Bibliography

1) Schmorl, G.: Die pathologische Anatomie der Wirbelsäule, Verhandl. d. deutschen orthop. Gesellsh., 21:3-41, 1927.

2) Mixter, W. J., and Barr, J. S.: Rupture of the Intervertebral Disk with Involvement of the Spinal Canal, *New Eng. Jour. of Med.*, 211:210-215, 1934.

3) Hampton, A. O., and Robinson, M. J.: Roentgenographic Demonstration of Rupture of the Intervertebral Disc into the Spinal Canal after Injection of Lipiodol, *Am. J. Roentgenol.*, 36:782-803. Dec., 1936.

4) Kubik, C. S., and Hampton, A. O.: Removal of Iodized Oil by Lumbar Puncture, *New Eng. J. of Med.*, 224:455-457, Mar. 13, 1941.

5) Wyatt, G. M., and Spurling, R. G.: Pantopaque, Surgery, 16:561, 1944.

6) Poppen, J. L.: The Herniated Intervertebral Disk: An Analysis of 400 Verified Cases, *New Eng. J. Med.*, 232:211-215, Feb. 22, 1945.

Physicians as Metaphysicians—Continued from page 168

than we like to admit, of sickness and agony. Why should not the physician teach us to accept suffering for what it is and to put it in its appropriate place in our thought, neither fearing it too much nor dismissing it too quickly? Should not the physician help us, for example, to see that since suffering is the common lot of man, the philosophy which says that pleasure is the end of life is suspect from the start? And particularly might not the physician help us to treat suffering in such a way as to realize its possibilities for the shared life? It seems to me entirely possible that the widespread agony of the present hour may have one of two opposite results. Either men's nerves will have become so raw and their emotions so harassed that we shall see this war continued into hundreds or thousands of battling groups which for the rest of our lifetime shall continue to struggle over racial or national or economic issues. Or else the realization that the suffering has been world-wide and that we have gone together as a human race through the valley of the shadow of death will bind us together and make us realize our common responsibilities as we have never realized them before. "One must have suffered very much in the world and have been very uncomfortable before there can even be any talk of loving one's neighbor," said Kierkegaard that brooding Danish genius of the nineteenth century. "It brings one closer to all mankind—this world-old experience," said our own William James. And Unamuno, the Spanish philosopher, observed, "Suffering is that which unites all living beings together; it is the universal or divine blood that flows through us all."

The question in every mind today is: "What can stop war?" Hear the answer of Sir William Osler: "The gradual growth of a deep sense of the brotherhood of man, such an abiding sense as pervades our own profession in its relation to suffering which recognizes the one blood of all the nations may perhaps do it."

This is why I have the temerity to suggest that in addition to his other tasks we might ask the physician to become a metaphysician. It seems to me that he has unusual qualifications, through his background and experience, for the task of helping us to tackle the problem of working out a philosophy of life and thinking it through consistently. He is the one who sees the connections between parts of experience that are often left unconnected. He can see the connection between science and our practical and humane interests, between our idealistic impulses and our realistic needs, between death and suffering on the one hand and the larger needs of our common human brotherhood on the other. Physician — help the metaphysician to heal himself!

The President's Page

To the Members of the Maine Medical Association:

It would seem to me that one of the activities which is most important to our profession at the present time is the development of good will between us and the returning veterans. The former soldiers are to be powerful factors in the American life for the next several years, and what we do for them may be reflected in their attitude toward the social changes which the politicians are now attempting to foist upon medical men.

Veterans are returning in great numbers. They require examinations, and more often, some type of treatment. If this is done in an indifferent manner, these restless and maladjusted boys will become disgruntled. Therefore, it is our job to plan a well rounded method for the handling of these difficulties.

We should have a Community Advisory Service Center financed through the United War Fund. A physician assigned by the Veterans' Administration would make the ordinary physical check-ups, and local physicians, — Specialists, should volunteer to take care of cases referred by this Center. This is a community problem. The work could be done in our local hospitals. The physicians should be canvassed to determine those of us who are willing to examine the veterans.

This idea is incorporated in the so-called Bridgeport Plan, and while experimental, is worthy of our consideration. Anything that will further the good-will relationship between veterans and physicians should be encouraged.

Adam P. Leighton, M. D.,
President, Maine Medical Association.

Editorial

Penicillin Inhaled as a Mist Cures Respiratory Infections

A highly concentrated solution of penicillin, inhaled as a mist, has brought complete relief to persons suffering from bacterial infections of the respiratory tract.

Herbert N. Vermilye, M. D., of Forest Hills, N. Y., in the September 22 issue of *The Journal of the American Medical Association*, reports the successful treatment of more than 200 patients with the inhaled drug known as "aerosol penicillin."

The conditions treated successfully include pneumonitis (inflammation of the lung), tonsillitis, sinusitis, sinobronchitis (inflammation of the bronchial sinuses), pharyngitis (inflammation of the throat), and bacterial asthma. These conditions all have a common denominator—the bacterial invasion of the respiratory tissues.

Aerosol penicillin has many advantages over the method of administration by injection into a muscle or vein, especially when bacterial invasions of the breathing apparatus are under treatment. With the injection method, frequent muscular or venous injections are necessary. This usually means that hospitalization and continual medical supervision with nursing care are essential. However, none of this is necessary with aerosol penicillin, since it may be easily administered in the home or in the doctor's office through a mouthpiece or oxygen mask.

Another advantage is that inhalation of penicillin mist introduces the drug directly into the site of bacterial invasion and produces a high local concentration at the point of the infection. Dr. Vermilye emphasizes the fact that aerosol penicillin was repeatedly found to control infections of the upper respiratory tract which were not cured by penicillin injections or which relapsed after its use.

The author stated that in an epidemic of an unclassified virus disease of the upper respiratory tract during the late winter months of the past year, aerosol penicillin was used to good effect. "While the virus infection itself was probably not influenced by the drug," the doctor pointed out, "the patients frequently were definitely benefited because secondary bacterial infections did not arise to complicate the original disease. Many patients appeared to be well after treatment for one or two days although penicillin was continued for about five days. Perhaps one factor in the rapid recoveries was the general feeling of well being and the increased appetite which commonly accompany aerosol penicillin treatment. Similarly the duration of colds has been repeatedly shortened because of the elimination of secondary bacterial invasions."

Dr. Vermilye adds that "the administration of penicillin by inhalation is suggested as a valuable substitute for the usual technic. It is an adaptable method, useful in the home by untrained persons and in the office. It can be utilized for continuous or intermittent administration of penicillin in severe as well as in less dangerous chronic infections, in which from three to five treatments during the day apparently are sufficient to effect removal of the infection."

American Medical Association House of Delegates to Convene in Chicago on December 3, 1945

The annual meeting of the House of Delegates, the policy-making body of the American Medical Association, will be held in Chicago for four days, beginning December 3, according to a telegram received at the Maine Medical Association office from Olin West, M. D., Secretary of the American Medical Association.

COUNTY SOCIETIES

Androscoggin
President, Romeo A. Beliveau, M. D., Lewiston
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Fort Fairfield

Cumberland
President, Henry P. Johnson, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Francis A. Winchenbach, M. D., Bath
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Ralph C. Stuart, M. D., Guilford
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Piscataquis

The annual meeting of the Piscataquis County Medical Society was held at the residence of Dr. Ralph Stuart in Guilford, September 20th, 1945.

The meeting was called to order by the President, A. M. Carde, M. D., at about 4.30 P. M. Minutes of the previous meeting read and approved. Secretary and treasurer report read and approved.

A nominating committee was appointed by President Carde as follows: Drs. Dore, Pritham and Valentine, who brought in the following slate of officers:

President, Ralph C. Stuart, M. D., Guilford.

Vice President, J. B. Valentine, M. D., Dover-Foxcroft.

Secretary-Treasurer, H. C. Bundy, M. D., Milo.

Board of Censors: W. E. MacDougal, M. D., 1946; N. H. Crosby, M. D., 1948; J. B. Valentine, M. D., 1948.

Legislative Committee: E. D. Merrill, M. D., 1946; G. E. Dore, M. D., 1948; M. O. Brown, M. D., 1948.

Delegate to Maine Medical Association, F. G. Pritham, M. D., Greenville Junction. Alternate, Doctor Stuart.

Slate of Officers voted for as presented.

Voted to hold next meeting at the Blethen House, Dover-Foxcroft, and that Drs. Carde and Bundy procure a speaker.

Members present: Drs. Carde, Dore, Valentine, Pritham, Stuart, Merrill, Marsh and Bundy.

H. C. Bundy,
Secretary.

Necrologies

Oramel E. Haney, M. D., 1876-1945

Oramel E. Haney, M. D., 68, World War One veteran and practicing physician in Portland, Maine, since 1909, for twenty years specializing in skin diseases, died suddenly September 4, 1945.

Doctor Haney was born at North Penobscot, September 21, 1876, and attended the former East Maine Conference Seminary at Bucksport, and was graduated from Bowdoin Medical School in 1903, serving his internship at the Maine General Hospital the following year. He was engaged in general practice in Boothbay Harbor, Maine, from 1904 to 1909, when he came to Portland. As a specialist he served on the staffs of the Maine General Hospital and the Maine Eye and Ear Infirmary, and was head of the clinic on skin diseases at the Public Health Service Dispensary.

He was a member of the Cumberland County Medical Society, the Maine Medical Association, and the American Medical Association.

At the beginning of World War One, Doctor Haney assisted in the reorganization of the Eleventh Company, First Maine Regiment, Heavy Field Artillery. He was commissioned a line officer and commanded the company in France.

He is survived by his widow, the former Caroline A. Lindsay; two sons, Richard G., a third-year man at the U. S. Naval Academy, Annapolis, Maryland; and Robert B., and a daughter, Barbara Ellen.

Robert G. Sommer, M. D., 1894-1945

Robert G. Sommer, M. D., died suddenly July 30, 1945, at his home in Richmond, Maine, from coronary thrombosis. He had been a practicing physician in Richmond for two years and seven months.

Doctor Sommer was born in Vienna, Austria, December 19, 1894, the son of the late Joseph and Matilda K. Sommer. He was graduated from the Vienna University and practiced in Vienna until he went to England for a few years. He came to the United States in April, 1940, and spent three years in Ohio where he was appointed resident at the Mercy Hospital in Hamilton.

Doctor Sommer was a member of the Lincoln-Sagadahoc County Medical Society, the Maine Medical Association, the American Medical Association, and of the Fidelitas Fraternity at the University of Vienna.

He is survived by his widow, Matilda Eberling Sommer, and a son, Robert George, Jr.

Notice

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Joseph E. Porter, M. D.*

Waterville: *Sisters Hospital*
1st and 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd and 4th Thursdays, 10.00 A. M.
Director, *A. H. McQuillan, M. D.*

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Boothbay Harbor	St. Andrew's Hospital	1st Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Lewiston	Central Maine General St. Mary's General	1st Monday 2nd Monday
Portland	Maine General Mercy	2nd Friday 3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters Thayer	2nd Tuesday Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

Proceedings

Maine Medical Association

HOUSE OF DELEGATES

AUGUSTA, MAINE

JUNE 24, 1945

SECOND MEETING OF THE HOUSE OF DELEGATES, JUNE 24, 1945

The second meeting of the House of Delegates convened at the Augusta House, Augusta, Maine, on Sunday, June 24, 1945, at 5:00 o'clock in the afternoon, with President Elect Leighton presiding.

CHAIRMAN LEIGHTON: The meeting will please come to order.

As the roll call has shown we have a quorum, I am going to ask for the report of the Nominating Committee, by the Chairman of that Committee, Dr. Francis J. Welch.

DR. WELCH: Mr. Chairman, before I give the results of that, I should like to make a motion to discontinue the Financial Advisory Committee, and delegate their powers to the President, the President-Elect and the Council.

This motion was duly seconded and was carried.

(Dr. Welch then read the report of the Nominating Committee as published in the July, 1945, issue of the JOURNAL, page 128.)

CHAIRMAN LEIGHTON: Thank you for your report, Dr. Welch. You have heard the report of the Nominating Committee, Gentlemen. What is your pleasure?

A MEMBER: I move the acceptance of the report of the Nominating Committee, and I also move that the Secretary cast one ballot for these nominations, electing them to their respective offices.

This motion was duly seconded and was carried.

SECRETARY CARTER: I have so cast the ballot.

CHAIRMAN LEIGHTON: And I declare them duly elected to their respective offices.

A report of the Reference Committee is unnecessary, since there were no resolutions or other business transacted by that committee.

At the present time, it is necessary to elect three Councilors. There are two whose terms are over, and the Fourth District has a vacancy due to the election of Dr. Piper as President-Elect.

Are there any nominations at this time from the First District?

DR. WELCH: Mr. Chairman, I move that Eugene Holt be elected as Councilor from the First District.

DR. CHARLES A. KINGHORN of Kittery: Mr. Chairman, it has been customary in years past, that this councilorship should be passed back and forth, and at the present time, it is York County's turn.

DR. GEORGE L. PRATT of Farmington: I would suggest that the delegates from Cumberland and York Counties retire and decide on a candidate.

CHAIRMAN LEIGHTON: We can leave that in abeyance until the election of the next Councilor, leaving the selection of a Councilor for the First District up to the delegates, as suggested.

Are there nominations for Councilor for the Second District, which takes in Oxford, Franklin and Androscoggin Counties?

A MEMBER: I suggest Dr. Ralph A. Goodwin of Auburn. He was selected this morning by the delegates of that District.

This nomination was duly seconded by Dr. Pratt and was carried.

CHAIRMAN LEIGHTON: Now, in the Fourth District, there is a vacancy because of the election of Dr. Piper as President.

SECRETARY: Mr. Chairman, I would like to nominate Roland L. MacKay, of Augusta, as Councilor of the Fourth District.

This motion was duly seconded and was carried.

CHAIRMAN LEIGHTON: Is there any unfinished business, previous to hearing from the First District and the election of their Councilor?

DR. CLYDE I. SWETT of Island Falls: I would like to say something at this House of Delegates' meeting, especially since listening to the fine talk given by our President, Dr. Bliss.

In Aroostook County, there has been quite a bit of heated discussion one way or another, and at our last annual meeting the 18th of this month, we had a paper read on the subject and discussed quite freely. I refer to the Wagner-Murray-Dingell Bill and its meaning to the medical profession in the State of Maine. I thought perhaps it would be well to bring the subject up to a state level, in an attempt to find out if any definite action should be taken or at least to get the viewpoint of the representative members of our association.

The discussion seemed to center about the national organization, about which you have all received information; The National Association of Physicians and Surgeons, I believe, is the name of it. Individual doctors are being asked to join, voluntarily, at $10.00 a year, for the purpose of placing, in plain language, a primary boycott upon any legislation which might be detrimental to the medical profession of the United States.

I shall stop my discussion at this point, to learn something, if I can from the members of the House of Delegates, as to what should be done; as President of the Aroostook County Society, I am sure my members will be interested in hearing what you have to say, and I am sure it will act as a guide to us, as well as to many other members of our profession who may not be as well informed as to what type of thing should be done.

A great deal has been said for and against it, and we are often criticized for being lukewarm in anything we might try to do for ourselves, so I wonder if we should take action, or whether or not we should let this slide by the board and let it rest.

CHAIRMAN LEIGHTON: Would any others like to speak on this subject, and answer the doctor's question, or is there anything further to add on this subject?

DR. PRATT: I was much interested in a conversation I had with Dr. Ebbett on this same subject. I wish that Dr. Ebbett would get up and tell you what he told me.

DR. P. L. B. EBBETT of Houlton: Mr. President and

members. My talk with Dr. Pratt was rather ex-officio, and off the board. I was merely telling him about the meeting that we had up there the other night when we discussed for several hours the passage of this bill, and what compulsory insurance would do for medicine.

One of the main things was whether it would improve the quality of service the public would receive, or whether it would be detrimental. I went into it pretty thoroughly, and, from what we could gain from the literature, from looking in the places where they had a panel system of medicine, it certainly didn't look propitious. At least their morbidity and mortality rates did not compare favorably with those in this country, nor did the class of medicine that those countries are receiving compare favorably with that which the same class of people in the United States are receiving. In other words, the class that have moderate incomes, and who feel, in England, under the panel system, they weren't beginning to get as good medical service. As far as I can find out, the same class of people were getting a superior type of service here in the United States, without any insurance of any kind.

This was evidenced in various ways there; especially was it true in the amount of increase in the sales of patent medicines, which increased very, very rapidly, since the panel system had been introduced.

Now, if they were getting good service, why do they do their own prescribing? That had increased greatly.

Another thing that we discussed was that if the Wagner-Murray-Dingell Bill should be passed, we would go on record as being absolutely opposed to it, and those of us who were present were asked if it was passed how many of us would join in and practice under that Act. Of course, all present agreed they would not; they would either go on practicing as free agents, or give up the practice of medicine, if necessary, and I may say that we went so far as to appoint a committee, which is to circularize the Aroostook County Society, to see what the viewpoint of the whole membership is on that matter, and how many, if, in fact, this proposed law did become in force, would refrain from practice, and how many would join in the system.

That is about all I think I discussed with Dr. Pratt.

When we get that circularization back, we would be glad to let the Maine Medical Association know how Aroostook County stands but at present all were opposed to the bill and also opposed to practicing under it, if it were accepted as law.

Chairman Leighton: Does anyone else desire to discuss this important subject?

Dr. LeRoy H. Smith of Winterport: Regardless of what laws are passed, they will never be successful unless we, as medical men, conform to their wishes and fall in line. If we say we will not do such a thing, it will not be possible to do it.

The disappointing thing to me has been perhaps the attitude of the younger medical men today who are being trained in the medical colleges, at government expense, more or less, and it came home to me when my old friend down in Connecticut, President of the Society, devoted a great deal of his time to combating all the efforts as put out from Yale University, combating the trend towards socialized medicine, and lo and behold, when his son came home from the end of his second year in medical school, he argued with his father about socialized medicine; he was all out for it! The doctor sat down and wept, figuratively speaking, copiously.

Now, I don't know what the attitude of the younger men is going to be, these men who are going to return from the military service, but whatever their attitude is, I think that we older ones can do as we darned please, and if we so elect, we can whip any law enacted that proposes to regiment us.

Dr. Kenneth E. Dore of Fryeburg: I am at a loss to know, as probably the President of the Aroostook County Medical Society is, just which one of these physicians' societies is in true worth, whether we should subscribe to their action in Congress and the Legislature in Washington. I am at a loss to know where to put my money, if it is to be put at all.

Chairman Leighton: Can anybody answer this question of Dr. Dore's?

Dr. Dore: They have one such society in Illinois, as I understand it, that is in the same position of attending to the same problem of this Wagner-Murray-Dingell bill, and they seem to have a group in their favor, too, but it is not as large as the National Physicians' Committee.

Now we know, whether we are conscious of it or not, that we are maintaining, I regret to say that we have found it necessary to maintain an active lobby in Washington. That lobby is under the control of the American Medical Association, and is on duty at all times. We are indirectly contributing to it. It is against the Wagner Bill, and I do not see any particular reason why we should contribute to both, inasmuch as their aims are somewhat identical.

A Member: In answer to the doctor's question; several months ago, there was an article on the Wagner-Murray-Dingell Bill in the *Saturday Evening Post,* and it mentioned three active forces in combating it. One was the American Medical Association; it also mentioned the National Physicians' Committee, and there was another committee, the name of which I am not familiar with, the Associated Physicians and Surgeons, the Illinois group.

That article, which seemed to be authoritative, mentioned all three as being active.

Dr. Swett: Perhaps I may enlighten you a little bit further. Whereas the A. M. A. is actively lobbying in Washington, it was not done until these other committees really forced the issue with them. The A. M. A. has done practically nothing, as far as the medical profession is concerned—and you can throw me out if you want to—in regard to this matter. The National Physicians' Association is merely a propaganda agency; it does nothing but propagandize the ideas against state medicine through literature, special and otherwise. Whereas the National Association of Physicians and Surgeons is an organization, born of a medical society, for the express purpose of placing a primary boycott upon the whole idea. In other words, if it can get the vast majority of individual physicians in the country to subscribe to their ideas, become members, sign statements that they actively will not associate themselves with any institution or individual who is in accord with the panal system. Then, no matter what type of legislation is put out, they can't make it go, because they have got to have the doctors do the job for them, and if the doctors refuse to be employees of the state, then the whole system is licked. Therefore, that is the simplest, easiest and most direct approach to the whole problem.

It behooves every individual doctor to do some straight thinking in regard to the whole subject, and if he feels opposed to the panel system sufficiently, then he most certainly should give this group his full support.

The reason I got on my feet today was not to express my personal views, but it was primarily to find out whether or not the Maine Medical Association had done any constructive thinking on the problem whatsoever. I think it is a very lukewarm thing; I don't find much thought on it; I don't find much said about it, and certainly there hasn't been much done about it in the past.

For a thing that is so vital to us, I feel that the Maine Medical Association should do some investigations, and help out the Maine doctors.

I give that as a direct challenge to the Association.

President Bliss: That seems to challenge the administration just coming to a close.

In response to the delegate's question, I should like to inform him that every Senator and Representative has been notified as to the attitude of the Maine Medical Association that we are against the Wagner-Murray-Dingell Bill. Some have been notified individually. Some representatives inquired directly from certain individuals for an expression of opinion. The lady from Skowhegan who sent out a questionnaire to certain of us had some illuminating replies, both as to the trend towards the socialization in medicine and the trends toward socialistic government in this country.

Those who represent the State of Maine in Washington are in no doubt as to how the Maine Medical Association stands. We expressed to them in plain English that we were wholly against any such system as proposed by the Wagner Bill, which is a general bill for social security with a clause in it relating to our practice.

CHAIRMAN LEIGHTON: Is there any further discussion, or is there any new business to be brought up at this time?

If not we are waiting for the nomination from your District, Dr. Kinghorn.

DR. KINGHORN: We haven't had any caucus, but if it is agreeable, I should like to place in nomination the name of Dr. Morse of Springvale. Dr. Waldron L. Morse of Springvale.

This motion was duly seconded and was carried.

(The name of Dr. Holt, as suggested previously by Dr. Welch, was withdrawn.)

DR. MACDONALD: I should like to find out, if I can, just where to put the money for the national organization to beat the Wagner-Murray-Dingell bill, whether it is the National Physicians' Committee or the Illinois group.

CHAIRMAN LEIGHTON: I am ashamed to say that I don't know. One of them, as I understand it, was trying to educate the laity, trying to teach them the fallacies of the bill. I sent $10.00 to the first one, the National Physicians' Committee. But I am ashamed to say that I don't know the answer to your question; I have lost interest in it.

DR. SWETT: We have sent a copy of the speech* made at our meeting to Dr. Carter, which outlines very clearly and concisely, I think, just the status of these associations. If that could appear in the JOURNAL, the men will get a clear picture of it.

* The Government, The Physician and National Health by Lloyd H. Berrie, M. D., published in THE JOURNAL OF THE MAINE MEDICAL ASSOCIATION, August, 1945, Page 135.

SECRETARY CARTER: We wrote him to that effect.

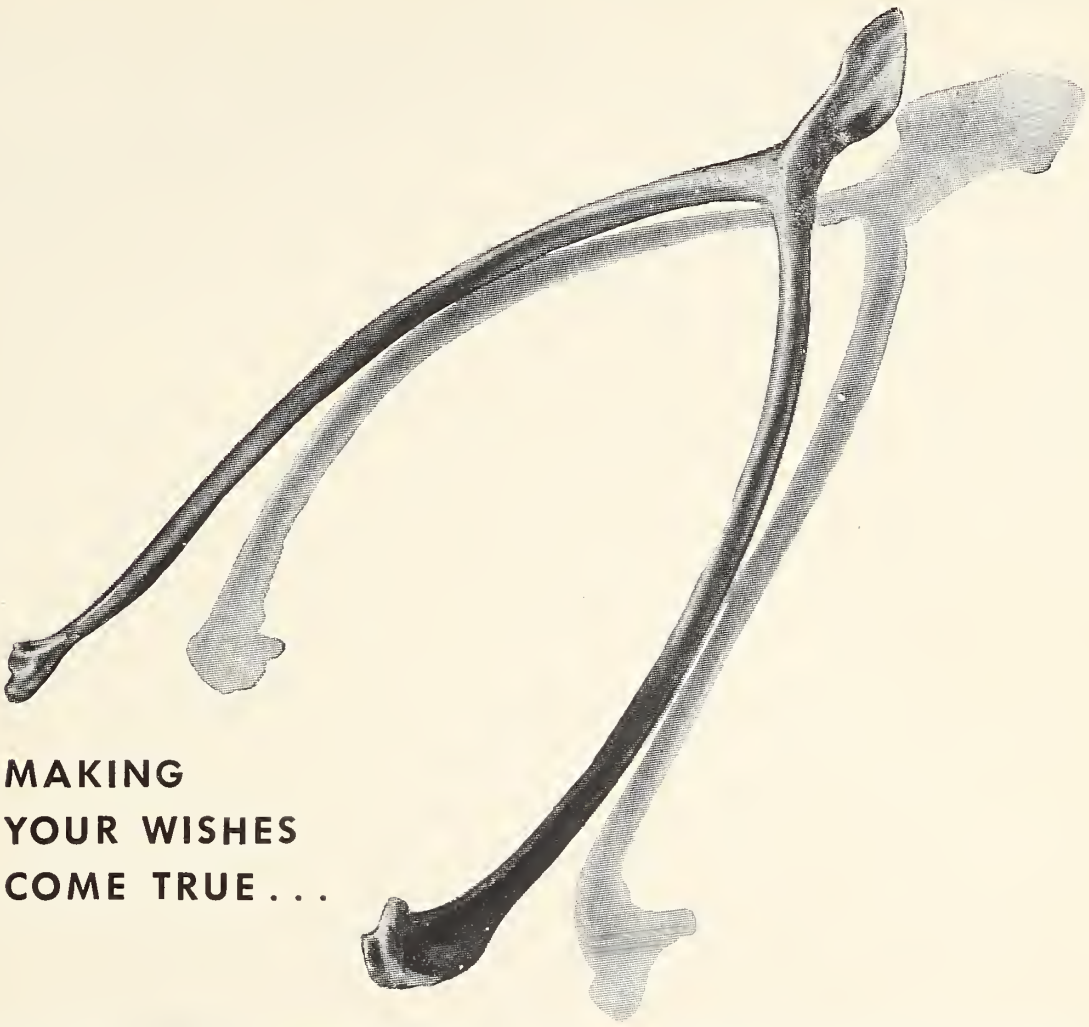
CHAIRMAN LEIGHTON: Is there anything else to be discussed at this time, Gentlemen? This is the opportunity that is given to you as the House of Delegates, to transact any business you desire to have taken up.

If there is no further business to come before the meeting, a motion is in order to adjourn.

SECRETARY CARTER: I move that we adjourn.

This motion was duly seconded and was carried.

(Whereupon, the second meeting of the House of Delegates was adjourned at six o'clock in the evening.)



MAKING YOUR WISHES COME TRUE . . .

One wish has been fulfilled. Won by 3½ years of deadly struggle. With God's help, we have prevailed.

Now we have a chance to make another wish come true. For most of us, the outlook is a bright one. If we will simply use the brains, the will, the energy, the enterprise . . . the materials and resources . . . with which we won our war, we can't fail to win the peace and to make this the richest, happiest land the world has known.

Your wishes have been wrapped in that bright outlook. Your wish for a cottage by a lake. For your boy's college education. For a trip you long to take. For a "cushion" against emergencies and unforeseen needs.

You can make those wishes come true by buying bonds today . . . buying them regularly . . . and holding on to them in spite of all temptation.

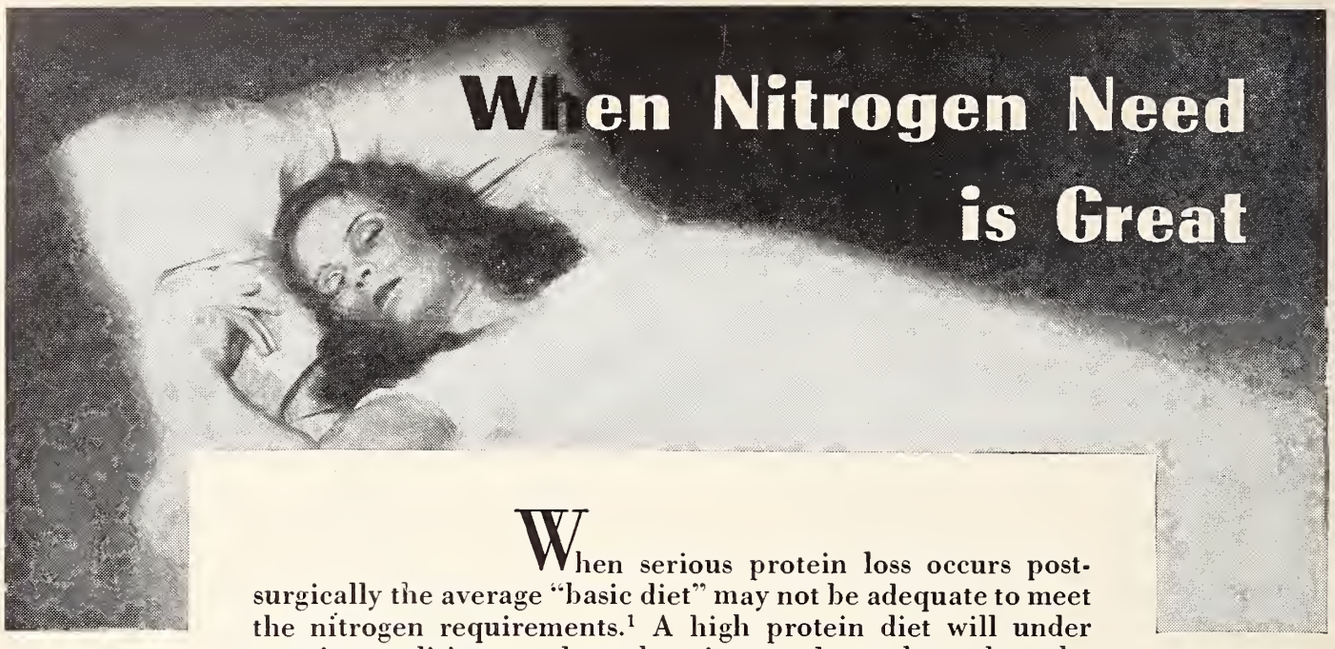
There's no safer, surer investment in the world. You can count on getting back $4 for every $3 you put in E Bonds—as surely as you can count on being a day older tomorrow.

So why not be patriotic and smart at the same time?

FULFILL YOUR WISH—BUY EXTRA BONDS IN THE GREAT VICTORY LOAN!

MAINE MEDICAL ASSOCIATION

This is an official U. S. Treasury advertisement—prepared under auspices of Treasury Department and War Advertising Council



When Nitrogen Need is Great

When serious protein loss occurs post-surgically the average "basic diet" may not be adequate to meet the nitrogen requirements.[1] A high protein diet will under certain conditions replace the nitrogen losses but when the necessary intake level cannot be reached or such a diet is not tolerated in sufficient quantity, supplementation becomes necessary.

Inadequate protein intake and depleted reserves have a relation not only to such concomitants of surgery as anesthetic damage, shock and wound healing, but also to resistance to infection, since protein is intimately linked with the mechanism of natural resistance as well as with the production of antibodies.[2]

When nitrogen need is great and supplementation becomes necessary, AMINOIDS* may be depended on as a source of readily assimilable amino acids, including those indispensable for the maintenance of human nitrogen balance, as determined by Rose.[3]

AMINOIDS, a protein hydrolysate product derived by enzymic digestion from beef, wheat, milk and yeast, is soluble in hot or cold liquids. It is palatable, thus assuring ready patient acceptance.

Two tablespoonfuls of AMINOIDS t. i. d. provide approximately 24 grams of protein as hydrolysate.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

Available in bottles containing 6 ounces.

Aminoids

REG. U. S. PAT. OFF.

A PROTEIN HYDROLYSATE PRODUCT

For Oral Administration

[1]Co Tui, et al: Ann. Surg., 121:228, 1945.

[2]Cannon, P. R., et al: Ann. Surg., 120:514, 1944.

[3]Rose, W. C., et al: J. Biol. Chem., 146:683, 1942; 148:457, 1943.

*The word Aminoids is the registered trademark of The Arlington Chemical Company.

THE ARLINGTON CHEMICAL COMPANY

YONKERS 1 NEW YORK

Arlington

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, November, 1945 No. 11

Nerve Compression Syndrome of Lumbar Nerves, Modern Concepts and Surgical Treatment

Albert S. Crawford, M. D.*

Since 1934, when Barr and Mixter popularized the clinical entity of "Ruptured Intervertebral Disk," countless articles have appeared on this subject from all over the world. The problem, which at that time began as a combined Neurosurgical and Orthopedic effort, is now of interest to all specialties who see and treat backaches.

Because it has become such a broad subject, all we shall try to do at this time is to put before you, as simply as possible, a sketch of the latest conceptions and describe very briefly the present methods of therapy.

Although the literature has contained some very divergent views as to the chief factors involved, there seems to be now more unanimity in the interpretations of the different experiences. There are a few who still feel that the protruded intervertebral disk is the cause of practically all backaches with sciatic radiation and that surgery is the cure-all for the condition. There are still some who stress the factors of disturbed posture due to muscular and ligamentous relaxation, with resultant subluxations of facets and involvement of the nerves in the foramina.

It is becoming more generally agreed that the problem is a combined one shared by the Orthopedic and the neurological surgeons. Most have found that there are several definite types of cases, one, the frank ruptured disk which comes on more or less acutely, with or without a previous history of back trouble; and two, the type with definite disturbed posture and prolonged backaches with a subsequent sciatic nerve involvement. There is a third type with a previous long or short history of backaches with not such marked disturbances of posture but with the same typical history of pain and neurological findings of nerve root impingement.

We have offered the term "Nerve Compression Syndrome" to cover all these various types of backache with peripheral nerve involvement. This term includes the intervertebral disks, the facet syndromes, and the others that are due to impingement of nerves by other structures to be enumerated later.

* From the Division of Neurological Surgery, Henry Ford Hospital, Detroit, Michigan, given before the Maine Medical Association, Augusta, Maine, June 24, 1945.

Anatomical and Pathological

We shall mention briefly a few anatomical and pathological facts which are fundamental to a better understanding of this problem.

1. The skeletal muscles are important in maintaining proper body posture. Gradual changes in these relationships result in abnormal pressures in some of the crucial areas of the spinal column, especially the lumbo-sacral articulation.

2. The ligaments of the vertebral column also play an important part in maintaining proper posture and the correct balance of movements between the various joints of the spine. Undue relaxation permits abnormal motions of the intervertebral disks and facets and at times pathological protrusions or ruptures of the disks.

3. The facets were constructed for functioning with the body in the horizontal position and are prone to give way, especially at the lumbo-sacral junction, under strain and stress with the body in the upright position, especially when there is relaxation of the main supporting muscles, as occurs with advancing years.

4. The lumbo-sacral joint is the extremely important junction between the vertebral column and the pelvis. It was also originally designed to function mainly in the horizontal position. The result of our being in the upright posture tends toward increasing instability as the muscles and ligaments relax with shifting backwards of the center of gravity which often results in abnormal pressure upon the posterior edge of the lumbo-sacral intervertebral disk with subsequent protrusion or even rupture of one segment of the disk.

5. The resulting increased pressure upon the lumbo-sacral joint also causes abnormally increased movements of the lumbo-sacral facets, with hypertrophy of the capsule and approximation of the adjacent facet borders thus encroaching usually upon the 5th lumbar nerves in the intervertebral foramina.

6. There is a constant discrepancy between the sizes of the lower lumbar nerves and their respective foramina. The 5th lumbar is the largest nerve and goes through the smallest foramen.

7. The nerves of the cauda equina in the dura enclosed spinal canal are quite freely moveable, but when they receive their dural sheathes and separate out to go through the intervertebral foramina they become quite fixed and thus cannot be shoved aside by an encroaching structure such as a protruded disk segment.

8. The intervertebral disk comprise ¼ of the total length of the spinal column. Their resiliency is an inherent quality but the support by the skeletal muscles and the checking by the various ligaments and facets are essential to the continued proper functioning of these disks.

Abnormal protrusions, and later ruptures, result from such disturbances in posture and from prolonged or repeated heavy work.

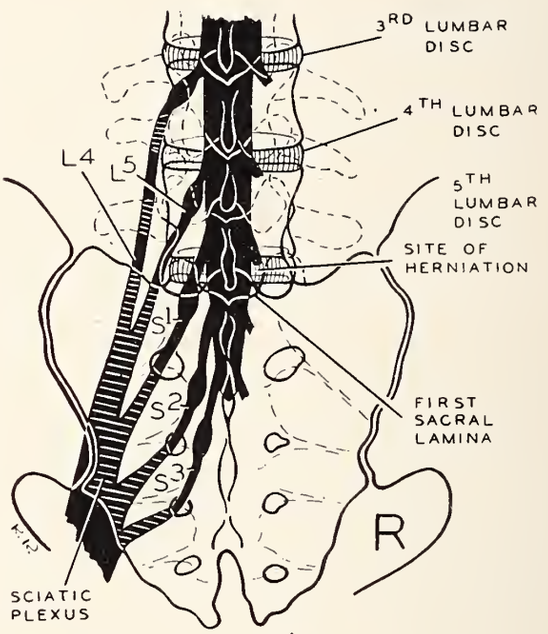


Fig. 1

Drawing over roentgenogram to show relation of first sacral and fifth lumbar nerve roots to intervertebral discs. (after J. Jay Knaja)

(Figure 1) Reproduced by permission from The Journal of Bone and Joint Surgery, XXVII, 239, April 1944.

9. The anatomical relations of the 1st sacral nerve, see Fig. 1, make it the most vulnerable of all the nerves of the cauda equina, which fact and also those mentioned in (2) and (4) above explain why over 90% of the operated cases show protruded or ruptured 5th lumbar disk. Some do occur higher up and are recognized as such. Some such do not cause sufficient symptoms to demand operation.

10. The dorsal supporting ligaments are thinnest laterally which explains why the disk segments are extruded most frequently laterally under the facet edges where the nerves are more vulnerable.

11. The ligamenta flava form an excellent

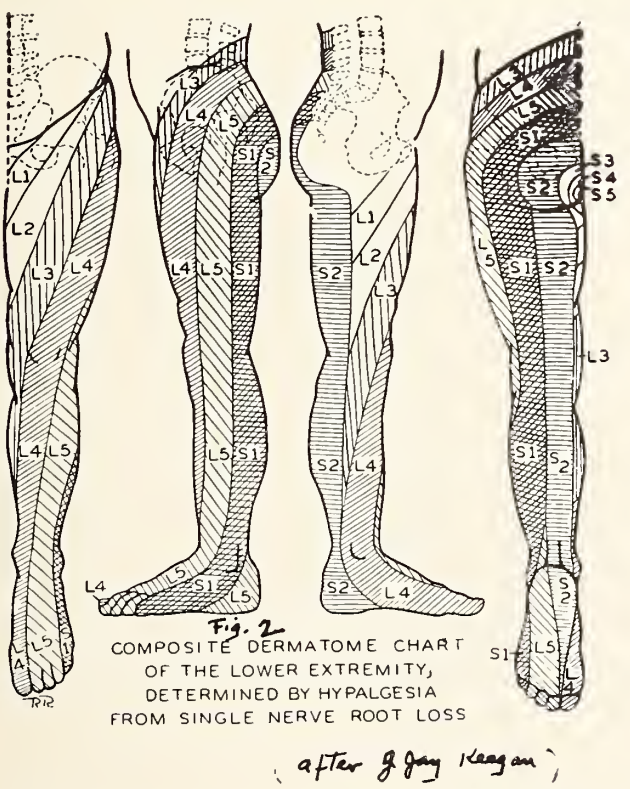
protection of the nerves as the main structure of the dorsal roof of the intervertebral foramina. But if they become thickened, as they quite often do, they can combine with hypertrophied facet capsules to form a definite compressing structure when abnormal extension constricts the foramen, especially of the fifth lumbar nerve.

Typical Case History

There is fairly typical history of these cases of nerve compression, as follows:

1. There has usually been a history of regular heavy work or some unusual strain. It may not be recognized by a few. Pregnancy is undoubtedly the factor in some cases with young women.

2. The pain is of sudden onset (40% in our series) or more gradual. It begins, usually, in the low back and gradually spreads to the leg. The distribution of this pain is determined by the nerves which are involved. Figure 2 shows



(Figure 2) Reproduced by permission from The Journal of Bone and Joint Surgery, XXVII, 240, April 1944.

the sensory dermatomes as described by Keegan. His differs a little from the Head zones and others described by Spurling and others but they all agree in the main and are valuable guides for exact localization. The pain is of the nerve root type, is constant or intermittent, lasting for from 2-3 weeks to several years. It is aggravated by coughing, sneezing, straining, stooping over, sitting and often comes on during the night interfering with sleep.

3. There is often loss of weight and morale.

4. There is usually no permanent relief from rest, physiotherapy, plaster casts or braces and they finally become quite incapacitated and are desperate for real relief of their pain.

Typical Physical Findings

The findings which are most common are enumerated herewith:

1. Diminution or absence of knee jerks (dermatones LIII and/or LIV). Diminution or absence of ankle jerks (dermatomes LV and/or SI).

2. Muscular weakness (usually some loss) in one or more dermatomes.

3. Pain on straight leg raising of affected side. Lasègue sign also usually positive.

4. Tenderness over the sciatic nerve.

5. List of the lumbar spine with tilting of pelvis (usually away from the affected side). There is muscle spasm in nearly all the cases.

6. Pain on forward flexion of spine and on lateral bending — usually more towards the affected side. Pain also on extension of the spine.

7. Tenderness on pressure over the transverse process and the affected facet (due to irritation of the dorsal branch of the involved nerve).

8. Pain aggravated by cough, sneeze and by jugular compression (lying or standing), (Naffziger's sign).

Differential Diagnosis

The condition must be differentiated from the following groups of cases:

1. Orthopedic conditions (not belonging to this group).

2. Primary neurological conditions, including spinal cord tumors.

3. Visceral disease — with nerve impingement or compression.

4. Systemic disease.

5. Psychalgias—which can simulate some of the signs and symptoms.

Aids in Diagnosis

1. X-rays frequently show narrowing of the intervertebral spaces when the condition is of long standing or when a considerable portion of the disk has been extruded. But the same finding is present in other conditions (some are congenital), and often the X-ray findings are negative in the presence of a well marked ruptured disk segment.

2. Notching shown by a contrast medium put intraspinally. Air is the safest but most unreliable in our experience. Lipiodal is the older substance used. Pantopaque, now the most popular, shows the defect graphically and can be removed at once after the X-rays have been taken. No absorbable material has yet been found which clearly demarcates the indentations.

3. Spinal puncture to rule out spinal cord tumors is usually done. The total protein content, if over 40 mgms. percent, may be helpful but is not infallable.

Incidence in Hospital Practice

From the reports of large medical centers one can obtain a fairly good idea of the frequency of occurrence of the condition. One of the recent reports from the Mayo Clinic (Orthopedic Dept.), (1940), states that about 13% of 5,500 back cases proved to have ruptured intervertebral disks. The same type of report from the following clinics gave the figures as follows: University of Michigan, 10-15% from 2,500 cases (1945). Lahey Clinic, 5% of 5,000 cases (1943). Our rate of incidence has been about 5%.

Treatment

1. The treatment should be conservative long enough to see if the pain is going to subside with rest. It should be for 2-3 weeks if acute, and longer — 3-4 months — if there is gradual improvement, with conservatism. This form of treatment cannot be enlarged upon here but it is mainly rest in bed, heat, traction, and some form of support, at first plaster of Paris — later braces or suitable surgical belts. If there is no improvement from conservative management then surgery is indicated without delay after 2-3 weeks.

2. The types of operation are:

a. Interlaminar approach, unilateral, popularized by Love, when the space is large enough to adequately deliver the pathological tissue.

b. Partial hemilaminectomy with removal of parts of adjacent facets for better exposure.

c. Hemilaminectomy of one or two laminae and adjacent facets for the cases where no protruded disk segment is found and the nerves are to be adequately decompressed.

Results of Surgery

The question of results is still an unsettled issue. There is no generally accepted criterion for estimation of results. Most reports have given results as the percentage of those completely relieved, those partially relieved and those with failure to relieve. Some have used the standard of when the patients returned to work, others of the patients own estimation of % of cure. This is a problem yet to be agreed upon.

But it can be said that from 60-65% have obtained complete relief and about 5 or 6% have been failures. The other groups obtained more or less complete relief of the leg pains but there remained some such residuals as backache, fatiguability, lameness of the affected leg, etc. Some that went back to work were still partially disabled. The question of the effect of Compensation upon the result has not been settled. Some have found it had no effect, others that it has had a definite effect. It is a problem also whether cases without a ruptured disk should be judged to be compensable.

A few of the figures are given to show in a general way the percentage of results obtained thus far by some of the medical groups. The figures given by the Mayo Clinic are 85% relieved; Lahey Clinic, 65% completely relieved, nearly 90% cured and improved, with 5% failures; and Hamby, about 95% cured and improved, with 5% failures.

Our series of over 150 cases, with a fairly good follow up, resulted in about 6% failures and over 60% with complete relief. An extra 34% had some residual difficulty such as occasional backache with hard work. Most were pleased with the results. There have been no deaths in our series. One report from the Mayo Clinic gave a mortality of less than 0.25% which is extremely low considering the large series reported.

Fusion

Because the problem is a combined one for Orthopedic and Neurological Surgery, each case should be carefully studied by both surgeons. Some cases will only need the limited hemilaminectomy to cure. Some will require a more extensive procedure and spinal fusion may be helpful in more cases to prevent weak backs and the development of a similar condition on the other side. This is a problem which needs further evaluation. I believe that a critical study of our cases as regards subsequent course, will show us that possibly more cases should be fused than are being done now. This opinion is at variance with some authors who seem to be opposed to fusions. We are conducting such a study now. A type of fusion which will prevent prolapse with the shortest period of stay in the hospital would seem to be the preferable one from the standpoint of expense to the patient.

Summary and Conclusions

A brief review has been made of the present concepts of back pain with sciatic nerve radiation which we have called "Nerve Compression Syndrome." Some anatomical and pathological facts which are related to this condition were enumerated. The typical history and physical findings of the condition have been described. The problems of diagnosis were mentioned. The treatment, both conservative and surgical, has been outlined. The results were given in a general way. It was emphasized that the problem is one for the combined study by Orthopedic and Neurological Surgeons. Probably more cases would be better if treated as a combined problem with exploration to rule out and to remove ruptured disks and other types of nerve compression and then to follow with a suitable stabilizing procedure such as spinal fusion if and when necessary. This is a condition for which much already has been accomplished. Even better results should follow a more careful and accurate diagnosis and applying the proper type of treatment.

References

Bradford, F. K., and Spurling, R. G. Intervertebral disc. Baltimore, Md., C. C. Thomas, 1941.

Breck, L. W., and Basom, W. C. Flexion treatment for low-back pain; indications, outline of conservative management, and new spine-fusion procedure. *J. Bone & Joint Surg.*, 25:58-64, Jan., '43.

Brown, L. T. Conservative treatment of backache. *J. Bone & Joint Surg.*, 14:157-164, Jan., '32.

Craig, W. M. Role of protruded intervertebral disk in production of low back and sciatic pain. *Rocky Mountain M. J.*, 39:98-101, Feb., '42.

Craig, W. M., and Walsh, M. M. Neuro-anatomical and physiological aspects and significance of sciatica. *J. Bone & Joint Surg.*, 23:417-434, April, '41.

Danforth, M. S., and Wilson, P. D. Anatomy of lumbo-sacral region in relation to sciatic pain. *J. Bone & Joint Surg.*, 7:109-160, Jan., '25.

Deery, E. M. Herniation of nucleus pulposus as complication of pre-existing low back instability. *Surg., Gynec. & Obst.*, 77:79-86, July, '43.

Ghormley, R. K. Low back pain, with special reference to articular facets, with presentation of operative procedure. *J. A. M. A.*, 101:1773-1777, Dec. 2, '33.

Hadley, L. A. Apophyseal subluxation; disturbances in and about intervertebral foramen causing back pain. *J. Bone & Joint Surg.*, 18:428-433, April, '36.

Hadley, L. A. Pathologic conditions of spine; painful disturbances of intervertebral foramina. *J. A. M. A.*, 110:275-278, Jan. 22, '38.

Hampton, A. O., and Robinson, J. M. Roentgenographic demonstration of rupture of intervertebral disc into spinal canal after injection of lipiodal, with special reference to unilateral lumbar lesions accompanied by low back pain with "sciatic" radiation. *Am. J. Roentgenol.*, 36:782-803, Dec., '36.

Hare, H. F., and Langs, L. W. Low back pain and sciatica with special reference to roentgen interpretation. *U. S. Nav. M. Bull.*, 41:1263-1272, Sept., '43.

Hyndman, O. R., Steindler, A., and Wolkin, J. Herniated intervertebral disk; study of iodized oil column; procaine test in different diagnosis from reflected sciatic pain. *J. A. M. A.*, 121:390-401, Feb. 6, '43.

Keegan, J. Jay. Neurosurgical Interpretation of Dermatome Hypalgesia with Herniation of the Lumbar Intervertebral Disc. *J. Bone & Joint Surgery*, 26:238-248, April, 1944.

Love, J. G. Protruded intervertebral disks, with not regarding hypertrophy of ligamenta flava. *J. A. M. A.*, 113:2029-2034, Dec. 2, '39.

Love, J. G., and Walsh, M. N. Protruded intervertebral disks. *Surg., Gynec. & Obst.*, 77:497-509, Nov., '43.

Love, J. G., and Walsh, M. N. Protruded intervertebral disks; report of 100 cases in which operation was performed. *J. A. M. A.*, 111:396-400, July 30, '38.

McEachern, D., and Cone, W. V. Clinical points on ruptured intervertebral discs; low back pain and sciatica. *Canad. M. J.*, 49:33-35, July, '43.

McKenzie, K. G., and Botterell, E. H. Common neurological syndromes produced by pressure from extrusion of intervertebral disc. *Canad. M. J.*, 46:424-435, May, '42.

Mitchell, C. L. Lumbosacral facetectomy for relief of sciatic pain; case report. *J. Bone & Joint Surg.*, 16:706-708, July, '34.

Mixter, W. J. Rupture of lumbar intervertebral disk; etiologic factor for so-called "sciatic" pain. *Ann. Surg.*, 106:777-787, Oct., '37.

O'Connell, J. E. A. Sciatica and mechanism of production of clinical syndrome in protrusions of lumbar intervertebral discs. *Brit. J. Surg.*, 30:315-327, April, '43.

Continued on page 194

Medical Care — Airborne

By Capt. Lorrimer M. Schmidt, M. C.*

Having been returned wounded to the United States from The European Theatre of Operations and being asked by so many people if my wounds had been received by jumping, it occurred to me that it might be appropriate to explain how medical care is brought to our airborne troops. In highly specialized groups, such as the armored and airborne divisions, the entire medical set-up has to be modified to meet the special needs of these groups in a similar manner as the basic training of the fighting elements of these groups is modified from straight infantry or artillery groups. Suffice to say the aid men, the litter bearers and the battalion aid station are still to be found but the manner in which they establish themselves and the evacuation of the wounded has been altered. Bearing this in mind an attempt will be made to clearly portray the medical care in an airborne division and some of the experiences encountered under combat in Europe.

Basicly, an airborne division is composed of three infantry and three artillery regiments, one of each of which is a parachute regiment and the other two are glider regiments. To these are added division headquarters, quartermaster troops, military police, signal corps, a battalion of engineers, a battalion of anti-aircraft and a company of medics. To all of these, except the last, are attached medical detachments. Training of these troops is basic and specialized, for example, in an infantry regiment all the soldiers familiarize themselves thoroughly with their firearms, hand grenades and the like, the artillery men with their 75 mm. guns, the engineers with building bridges, roads, mine sweeping and the like, the medics with all forms of emergency medical treatment. This, all troops must do in the dark as well as in the daylight. Proficiency is obtained only by constant repetition which at times becomes boresome to the troops, but it is all important for the troops to know their job so well that darkness does not interfere with the success of the mission. This is borne out by an incident that happened on Tennessee maneuvers. The medics were called out one night to take care of a fractured leg. They did a beautiful job. The army leg splint was carefully and well applied, the slings were in their proper position, the wound had been adequately treated since it was a compound-comminuted fracture. The only trouble was that the splint had been applied to the good leg rather than to the fractured one.

Specialized training consists of training the men to be either paratroopers or glider men. The paratroopers are taught how to jump, how to land to minimize the possibility of fractures, how to pack their "chutes" so that they will be certain to open and how to free themselves quickly from their "chutes" in order to attack the enemy rather than becoming a casualty (seconds count here). An incident occurred in England which well illustrates the importance of correctly packing a parachute and correctly landing from a jump. An entire battalion of an artillery regiment was making a practised jump. Forty-six planes loaded with twenty-four men each opened their doors over a designated spot and the men parachuted to the ground. There was a stiff wind blowing. Three of the parachutes failed to open and the men came hurtling to the ground only to be killed. Ninety-six men went to the hospital with fractures of the legs. Likewise are glider men specially trained. All equipment is taken into combat in gliders. This equipment is either piled into jeeps and trailers or, in the case of guns (British six-pounder, American 57 mm.), taken in as one piece. The equipment must be securely loaded and lashed or tied into place. The weight of equipment and men must be known accurately and the center of gravity determined. A shift in the center of gravity causes the glider to become detached from the towing plane, all control over the glider is lost and the glider goes crashing to the ground. The personnel riding in the glider carry no parachutes. If the load shifts and a crash landing occurs and any personnel come out alive, it is a miracle.

In the medical detachments and in the medical company both paratroopers and glidermen

* Battalion Surgeon, 155th Airborne Anti-aircraft Battalion, 17th Airborne Division, U. S. Army.

are to be found. Medical corpsmen and medical officers jump with the men or go into combat as glider troops. Equipment for battalion aid stations, for regimental aid stations, for the medical company installations are all loaded into jeeps and trailers and travel in gliders. The jeeps are quickly converted into ambulances and will carry four litters. In an airborne invasion the aid men accompany their respective companies, either parachute or glider, the remaining personnel and equipment as soon as discharged from the gliders are collected together and the various medical installations are set up. The aid stations are near the front lines. The collecting and clearing stations of the treatment sections of the medical company as close to the center of the division as possible. Evacuation of the wounded commences. Sometimes a field hospital is flown in to support the medical company. Here are the wounded taken care of until they can be further evacuated by air or until other army units can open up a corridor from the outside into the airborne division and the wounded then evacuated over the road to the various army hospitals. Since an airborne division is surrounded by enemy from two to three days or for eight days as was the 101st Airborne Division in the Battle of Bastogne, the corpsmen and officers have to be trained to undertake all types of emergency surgery which would normally be performed in the medical installations in the rear echelons. Our men were thoroughly trained.

A soldier wounded up front is treated by the aid man, then taken either by litter or jeep ambulance to the battalion aid station, then to the regimental aid station and finally to the clearing station. From there he may be evacuated over the road or by air or he may remain for further treatment if his condition is such that he cannot be moved with safety or because there is no other place for him to go to. Treatment is prompt and early in this war. Morphine syrettes and plasma have saved great numbers of lives. All airborne troops had morphine syrettes and were taught how to self-administer the morphine. Plasma was in the hands of the battalion aid station but was sent forward with the jeep ambulances. One of the handicapping factors to the use of morphine and plasma during the battles of last winter (it being the coldest winter in Europe in one hundred years) was the freezing of the solutions. The aid men soon learned to keep morphine from freezing by fastening the syrettes under their armpits and the enterprising jeep ambulance drivers kept the plasma under the hoods of their jeeps. Thus was it possible to give morphine immediately and to administer plasma on the jeep ride to the aid station and so combat shock early and effectually.

The cold of last winter produced another harassing factor for the troops. There were untold cases of foot trouble ranging all the way from frost-bite, through trench foot or immersion foot to actual freezing of the feet. All troops had been trained in care of the feet and at every possible opportunity clean socks were sent to the front daily. But it was a difficult task to get the men in the fox holes to rub one anothers' feet, nor was this always feasible in a fast moving campaign. Then again transportation of materiel to the front sometimes broke down due to enemy activity.

Other factors leading to deaths and casualties among our troops are the insatiable curiosity of Americans and the incurable habit of collecting souvenirs. Many a limb has been lost or a death occurred from the picking up of a German hand grenade or a shoe-box mine and the looking into them to see what made them tick. In one of our batteries one officer and three enlisted men were killed and four others were seriously wounded by the explosion of a shoe-box mine that had been collected for a souvenir and that supposedly had been rendered inert.

The civilian population along the frontier were a constant source of trouble. Many a door was booby trapped as we slept hoping to wound or kill some of us the next morning. In Luxembourg the civilians of an entire town had to be placed under arrest and taken to the rear because, during the night, they had cut all communications to gun positions and destroyed fire direction. Even the children had to be watched as they would cause sabotage to the vehicles.

Briefly would I like to mention the treatment of medical personnel by the Germans. I have seen our medics deliberately shot down by SS troops or pinned down by small arms fire for hours to deprive American troops of medical care. In the massacre at Malmedy the medical officer was the first person shot by the Germans. And all this despite red crosses on hel-

mets and sleeves and in spite of the Germans professing to uphold the Geneva Convention. Again I would like to state that in the entire Battle of the Ardennes I never saw a dead German soldier who was not dressed in American army clothing either under his own or more often over his own.

Lastly I should like to describe the airborne movement across the Rhine of last March. Since I had by that time been evacuated to the United States this description is in the words of my division surgeon and taken from a letter he wrote to me following this invasion.

"It was a very hot deal—especially when we happened to come in. Things were happening in all directions at the same time. Despite the ack-ack and the small arms coming through the glider no one got hurt. The pilot got some in his flak suit but none went through. The whole place was covered with haze and smoke from burning gliders, planes, houses, etc. We were making our last turn and coming in on our final approach when suddenly something jarred hell out of things in general. I was in the process of pulling off the emergency side door when I felt it go. I looked through the front end and saw that we were in a spin as the trees, ground and clouds were rotating over and over again. We were still a hundred feet up when this happened. Then came the crash and the glider began to bounce and disintegrate. I thought it would never stop. The "crate" was a complete and total wreck, broken into three pieces, nose all smashed to hell, etc. Fortunately it was a flat spin or we would all have been pushing up daisies. We all got cut up some and twisted up. Following that we were pinned down by small arms fire and everytime we tried to get the jeep out they would start shooting again. Why we were not killed I'll never know. We finally got the station up in about fifty minutes and were plenty busy from then on for two to three days." And from my own detachment: "Things were plenty tough, Captain. Only two of your four gliders made it. And all of us now wear Purple Hearts. The others were all killed." Such are the trials in bringing medical care to the wounded in an airborne division during an airborne movement.

Lorrimer M. Schmidt,
Capt. M. C.

Capt. Lorrimer M. Schmidt was commissioned 28 November, 1942, in the Army of The United States and received his basic training at the MDRP, MRTC, Camp Pickett, Virginia. Following the completion of the course at Camp Pickett, he became Battalion Surgeon of the 414th Armored Field Artillery Battalion, 20th Armored Division, Camp Campbell, Kentucky.

In October, 1943, he attended an Army Course for Medical Officers at Columbia University School of Medicine, New York City, in Surgery of The Extremities. From January to April, 1944, he was an instructor in Field Medicine and Surgery, Battalion Surgeons' Assistants Course, OCS-MAC, Camp Barkeley, Texas.

The Army transferred him in May, 1944, to the 17th Airborne Division where he became Battalion Surgeon to the 155th Airborne Anti-aircraft Battalion. He trained for and became a gliderman. In August, 1944, the division sailed overseas and was stationed in England for four months. On Christmas Eve they flew to France and were committed to action in the Belgian Bulge.

Capt. Schmidt saw action in the Battle of The Ardennes and The Battle of The Rhineland. He was wounded in action in Luxembourg, 7 February, 1945, and was evacuated by air to the United States. He is now a patient in the Lovell General Hospital, Fort Devens, Mass. He has been awarded the Order of The Purple Heart and, on 30 May, 1945, received the Bronze Star. The citation reads as follows:

"Headquarters 17th Airborne Division, APO 452, U. S. Army, 12 April 1945, General Orders, Number 16.

"V. AWARD OF BRONZE STAR MEDAL—Under the provisions of AR 600-45, 22 September 1942, as amended, and pursuant to authority contained in Memorandum Number 34, Headquarters Ninth United States Army, 8 September 1944, the Bronze Star Medal is awarded to:

Continued on page 198

The President's Page

To the Members of the Maine Medical Association:

I would strongly recommend that the Association members read the recent speech of Senator Clyde M. Reed of Kansas, delivered on October eleventh, and last week printed and published in the Congressional Record. It is indeed very illuminating and expresses emphatically, the feelings of most of us, anent the release,—or better still,—the non-release of our doctors from the medical corps of the armed forces. Would that more of our Country's leaders and statesmen would take such an interest in this matter and speak forth their feelings and ideas concerning the clumsy and thoughtless treatment that our medical men are receiving!

We in Maine,—and of course in all the States, have suffered from a paucity of medical practitioners during the War. It was to be expected. We cheerfully accepted the inevitable and have even curbed our ire when the invasion of non-combatant pseudo-medical men took place, with the subsequent usurpation of medical practice.

Now that the War has ended, it is obvious, for some reason or other, that our medical men are being too slowly released. We need them here at home, and with little or nothing to do, for the most part, in their respective assignments, they should be given every opportunity to resume practice.

Why not write to our State Senators or Congressmen, to the Surgeon General of the Navy and of the Army and voice our sentiments? We each of us, have some medical officer in whom we are interested, who clamors for the right to come home and start in again where he left off.

They did their part. They were unselfish and patriotic. We who were allowed to "stay on the job" should give a little thought to him who gave his all and did his duty.

Adam P. Leighton, M. D.,
President.

Editorial

Inadequate Medical Resources Seen As Chronic U. S. Problem

Officer Praises War Record of U. S. Army Medical Corps, But Deplores Wastage; Urges Analysis of Federal Needs

Writing on "Our National Medical Resources" in the October 6 issue of *The Journal of the American Medical Association,* Lt. Col. Michael E. DeBakey, Medical Corps, Army of the United States, says that "the inadequacy of the national medical resources which became so acutely evident during the war is by no means a temporary phenomenon."

"It is a chronic problem," he adds. "It was merely aggravated by the circumstances of war. The shortage still exists, even though the war is over, and many factors now operative threaten to make it even more acute. Economic and social forces are pressing for prompt and effective solution of problems which still are only partially defined."

Colonel DeBakey says that the record of the U. S. Army Medical Department during the war has been justly acclaimed.

"The soldiers of this country were better cared for than any other soldiers in the world have ever been cared for. The wounded were saved from death and were returned to military effectiveness in numbers never before considered possible. Men were saved from disability and deformity who in previous wars would either have lost their lives or would have lived out their days in invalidism and worse. . . .

"This, however, is the brighter side of the picture. The darker side is the wastage which inevitably occurred in spite of the endeavor to use the limited supply of medical personnel to the best advantage. The very constitution of our military establishment required, and still requires, the inefficient and extravagant provision of separate medical installations for the Army, the Navy, the Air Force and the Veterans' Administration. Often these separate facilities were, and still are, literally side by side. Each installation was, and still is, provided with a more liberal allowance of beds than its census of patients has ever required with the exception of certain hospitals, particularly in the later months of the war. Each installation was, and still is, usually staffed with adequate numbers of medical personnel, though many hospitals were, and are now, inadequately staffed from the standpoint of medical efficiency and specialized competence."

Colonel DeBakey, who is on leave as Assistant Professor of Surgery of Tulane University of Louisiana School of Medicine at New Orleans, believes that the war has multiplied the medical responsibilities of the nation.

Pointing to the many thousands of sick and wounded soldiers who will need medical care, coupled with the fact that the standard of medical care expected by the public has risen during the course of the war, Colonel DeBakey says:

"The medical resources of the country are simply not adequate to meet the demands for medical care as they at present exist."

The supply of physicians, he says, is not great enough numerically to provide for a high standard of medical care for both civilian and government requirements. One of the reasons he cites was "the unfortunate policy" of Selective Service in refusing to defer prospective medical students which "will result for some years to come in a decrease in the usual annual increment of physicians."

"The number of medical specialists," Colonel DeBakey adds, " is even less likely to be increased to any great degree within the immediate future, partly because the facilities for specialized training are even more sharply limited than are the facilities for undergraduate medical education and partly because of the military policies which curtailed the training of specialists during the war."

Colonel DeBakey believes that the first step in solving the medical care problem of the country, if one is scientifically found to exist, would be an analysis of the medical resources of the nation in relation to its medical needs,

Continued on page 198

Necrologies

Eugene Boutelle Sanger, M. D.
1871 - 1945

Eugene B. Sanger, M. D., for many decades one of Maine's most prominent physicians and surgeons, died at his home in Bangor, Tuesday, September 11, 1945.

Doctor Sanger was a member of many of the leading medical organizations and had political and business associations of prominence.

He was born in Bangor on February 20, 1871, a son of Doctor Eugene F. and Elizabeth Sanger, prominent residents of Bangor. Doctor E. B. Sanger was educated in Bangor public schools, Phillips Exeter Academy, Yale University and Columbia University.

After being graduated from medical college in 1894, he was an interne at Bellevue Hospital in New York, having many interesting experiences there, including frequent contacts with Theodore Roosevelt when the latter was police commissioner of New York.

Coming to Bangor for practice of medicine, he became one of the leading physicians and surgeons of Maine. He was a member of the American College of Physicians and Surgeons, among other organizations.

He married in 1902, Miss Ethel Field, daughter of Mr. and Mrs. Charles E. Field, who died many years ago.

Surviving are a daughter, Mrs. Charlotte Averill, and two sons, Eugene B. Jr., and Sabine B. Sanger.

Doctor Sanger was surgeon general on the staff of Governor Cobb in 1904-05. He was a 32nd degree Mason.

He was a director of the Merrill Trust Company, president of the Bangor Automobile Association, president of the Bangor Opera House Association for a time, member of the Penobscot Valley Country Club and Canoe Club, member of the Tarratine Club which he was most instrumental in building, member of the Yale Club of Boston, member of the Mystic Shrine, first president of the Maine State Automobile Association, chairman of the Republican county committee.

He was active in Republican politics for many years.

He was one of the leading members of the surgical and medical staff of the Eastern Maine General Hospital for many years.

Doctor Sanger was made an Honorary Member of the Maine Medical Association in 1944 in recognition of fifty years in the practice of medicine.

Oliver J. Caza, M. D.
1881 - 1945

Oliver J. Caza, M. D., of Skowhegan, Maine, died October 26, 1945, in the New England Baptist Hospital, Boston, Massachusetts.

He was born in St. Anicet, Quebec, Canada. He was graduated from Laurant Seminary, Montreal, and received his medical degree in 1907 from the the University of Montreal Faculty of Medicine. He had hospital practice at Notre Dame and Hotel Dieu hospitals in Montreal, before starting his practice in Skowhegan in 1908.

Doctor Caza was a member of the Somerset County Medical Society, the Maine Medical Association, and the American Medical Association.

He was married, May 4, 1908, to Alma Latreille of St. Anicet, Quebec, who survives, as do two children, Aime and Rita; a sister and a brother.

Harold Fisher Atwood, M. D.
1885 - 1945

Harold F. Atwood, M. D., 60, died at his home in Buckfield, Maine, October 5, 1945.

He was born January 1, 1885, at Norwood, Massachusetts, the son of Horace and Clara Talbot Atwood. He was graduated from Norwood High School in 1904, Bowdoin Medical School in 1908, and interned at the Tremont Dispensary, Boston, later taking a special course at the Pratt Diagnostic Hospital.

Doctor Atwood started practice in West Sumner, Maine, in 1908, and moved to Buckfield in 1911. He was on the staff of the Central Maine General Hospital in Lewiston for a time, and served on the Board of Health at Buckfield for several years. In World War I, he enlisted in the Medical Corps and held the rank of Captain.

He was a member of the Oxford County Medical Society, the Maine Medical Association, and the American Medical Association.

Surviving are his widow, Mrs. Lenora Stone Atwood; a sister, and a brother.

Benjamin Lake Noyes, M. D.
1870 - 1945

Benjamin Lake Noyes, M. D., 75, of Stonington, Maine, died of pneumonia in the Eastern Maine General Hospital, Bangor, October 16, 1945.

He was born at Lisbon Falls, Maine, May 30, 1870, the son of Doctor George B. and Sarah Lake Noyes. He attended the Grand Manan, N. B., schools and was graduated from Bowdoin Medical School in 1895.

Doctor Noyes had practiced medicine in Stonington for fifty years, and was widely known in that section of the State for his ability as a physician and surgeon.

He was a member of the American Medical Association, the Maine Medical Association, and the Hancock County Medical Society. In June, 1945, he was presented with the Maine Medical Association's fifty-year service medal, and made an Honorary Member of the Association.

Surviving are his widow, Estelle; two daughters, a sister, and three brothers.

Nerve Compression—Continued from page 187

Oppenheimer, A. Pathology, clinical manifestations and treatment of lesions of intervertebral disks. *New England J. Med.,* 230:95-105, Jan. 27, '44.

Poppen, J. L. Management of ruptured intervertebral discs. *Proc. Interst. Postgrad. M. A., North America* (1943), pp. 118-120, '44.

Roberts, F. Nature and functions of intervertebral discs. *Brit. J. Radiol.,* 17:54-59, Feb., '44.

Scott, W. G. Low back pain resulting from arthritis and subluxations of apophyseal joints and fractures of articular facets of lumbar spine. *Am. J. Roentgenol.,* 48:491-509, Oct., '42.

Spurling, R. G., and Thompson, T. C. Notes on diagnosis of herniated nucleus pulposus in lower lumbar region. *Surgery,* 15:387-401, March, '44.

Vinke, T. H., and White, E. H. Congenital narrowing of lumbo-sacral space. *Surg., Gynec. & Obst.,* 76: 551-555, May, '43.

Williams, P. C. Lesions of lumbo-sacral spine; acute traumatic destruction of lumbo-sacral intervertebral disc. *J. Bone & Joint Surg.,* 19:343-363, April, '37.

Williams, P. C. Reduced lumbo-sacral joint space, its relation to sciatic irritation. *J. A. M. A.,* 99: 1677-1682, November 12, '32.

Williams, P. C., and Yglesias, L. Lumbosacral Facetectomy for Post-Fusion Persistent Sciatica. *J. Bone & Joint Surg.,* 15:579-590, July, '33.

Wright, J. Mechanics in relation to derangement of facet joints of spine. *Arch. Phys. Therapy,* 25: 201-206, April, '44.

Yaskin, J. C., and Tornay, A. S. Protruded intervertebral disk and hypertrophied ligamentum flavum. Criteria for diagnosis and indications for operation, with analysis of 50 surgically treated cases. *Am. J. M. Sc.,* 206:227-233, Aug., '43.

COUNTY SOCIETIES

Androscoggin
President, Romeo A. Beliveau, M. D., Lewiston
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Fort Fairfield

Cumberland
President, Henry P. Johnson, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Francis A. Winchenbach, M. D., Bath
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Ralph C. Stuart, M. D., Guilford
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, John F. Hanson, M. D., Machias
Secretary, John Young, M. D., Jonesport

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Cumberland

The Cumberland County Medical Society met at the Maine Eye and Ear Infirmary, Portland, Maine, on October 19, 1945. A very interesting clinic was presented at 5.00 P. M., at which there was a good attendance. An excellent dinner was served at 6.30 P. M., and was followed by a business meeting. The society unanimously approved a brochure of advertising material regarding the Wagner-Murray-Dingell bill sent to the society by the National Physician's Committee. The application of Dr. Saul Polisner, of Portland, for transfer from the Knox County Medical Society to the Cumberland County Medical Society was unanimously approved. The application for admission to the society of Dr. William Freeman, of Yarmouth, was referred to the Council.

The society was entertained by Dr. Joseph Ross, Assistant Professor of Medicine at the Boston University School of Medicine. He presented a most interesting paper entitled "Artificial Radio-Activity in Medicine." His introduction consisted of an explanation of isotopes, differences, similarities, and their various characteristics. The cyclotron, which has made possible the formation of the various isotopes, was explained. The radio-active isotopes are especially useful in tracing elements which are injected into the body. The fate of many of these elements is now more definitely understood. From the therapeutic standpoint it was brought out that radio-active iodine offers a very definite promise in the treatment of hyperthyroidism. Radio-active phosphorus offers a relatively simple but at present expensive way of treating leukemia and lymphomas. Radio-active strontium has not been studied adequately, but the few cases on which it has been used indicate that it may have some possibilities in the treatment of bone tumors.

JOSEPH E. PORTER, M. D.,
Secretary.

Hancock

A regular meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, Wednesday evening, October 10, 1945.

Roscoe L. Mitchell, M. D., of the State Department of Health and Welfare, was present as a guest of the society. He outlined some of the new laws pertaining to medical practice as passed at the recent legislative session.

Raymond E. Weymouth, M. D., of Bar Harbor, recently released from service with the Army Air Forces, spoke on the subject "Army Medical Organization."

J. H. CROWE, M. D.,
Secretary.

Penobscot

The October meeting of the Penobscot County Medical Association was held at the Bangor House, Bangor, Maine, Tuesday, October 16, 1945, with dinner at 6.30 P. M.

Interim reports covering the last meeting, and the summer vacation, were read and approved.

Notice was made of the death of a member, Eugene Boutelle Sanger, M. D., on September 11th, at his home in Bangor. A committee consisting of L. H. Smith, M. D., of Winterport, Chairman; H. C. Scribner, M. D., Bangor; and L. S. Mason, M. D., Bangor; was appointed by the President, S. S. Silsby, M. D., to bring in resolutions on the death of Dr. Sanger.

It was voted that the Penobscot County Medical Association sponsor professional notices in the newspapers relative to the return of our members from the armed services and re-opening civilian medical practice.

Dr. Silsby appointed a committee to bring in nominations for society officers at the annual meeting in November. This committee consists of Past Presidents A. W. Fellows, M. D., Bangor, Chairman; E. T. Young, M. D., Millinocket; and M. C. Moulton, M. D., Bangor.

Adam P. Leighton, M. D., of Portland, President of the Maine Medical Association, was guest for the evening. Dr. Leighton spoke informally on the subject: "Medical Education, Service and Insurance."

E. L. Herlihy, M. D., of Bangor, spoke on the subject: "Medical Education in Maine."

Following a very interesting question period and discussion, it was moved, seconded and favorably voted, That the Penobscot County Medical Association favor the establishment of a Medical School in Maine.

Attendance, 41.

FORREST B. AMES, M. D.,
Secretary.

Washington

The annual meeting of the Washington County Medical Society was held at the St. Croix Hotel, Calais, Maine, October 19, 1945.

Following a chicken dinner served at 6.15 P. M., there was a short business meeting at which the following officers were elected for the coming year:

President, John F. Hanson, M. D., Machias.

Vice President, James C. Bates, M. D., Eastport.

Secretary-Treasurer, John Young, M. D., Jonesport.

Delegate to the 1946 annual meeting of the Maine Medical Association: Walter N. Miner, M. D., Calais. Alternate,: DaCosta F. Bennett, M. D., Lubec.

Censors: P. J. Mundie, M. D. (three years); Walter J. Gilbert, M. D. (two years); Leslie W. Brownrigg, M. D. (one year).

The business meeting was followed by an open round table discussion. Eight members were present.

ALLEN H. KNAPP, M. D.,
Secretary.

Members Released from Military Service

Androscoggin County Medical Society:

Beeaker, Vincent,	Lewiston
Clapperton, Gilbert,	Lewiston
Cox, William V.,	Auburn
Steele, Charles W.,	Lewiston
Webber, Wedgwood P.,	Lewiston

Aroostook County Medical Society:
Toussaint, Leonid G., Fort Kent

Cumberland County Medical Society:
Blaisdell, Elton R., Portland
Johnson, Gordon N., Portland
Love, Robert B., Gorham
Moore, Roland B., Portland

Franklin County Medical Society:
Brinkman, Harry, Farmington
Reed, James W., Farmington

Hancock County Medical Society:
Weymouth, Raymond E., Bar Harbor

Kennebec County Medical Society:
Bull, Frank B., Gardiner
McWethy, Wilson H., Augusta
Murphy, Norman B., Augusta
Towne, Charles E., Waterville

Oxford County Medical Society:
Howard, Henry M., Rumford
Wilson, Harry M., Bethel

York County Medical Society:
Cobb, Stephen A., Sanford
Gould, George I., Auburn

The above listed names of Members Released from Military Service have been received by the Secretary of the Maine Medical Association as of October 27, 1945. Additional names, when reported to the Secretary, will be added to this list in future issues of the JOURNAL.

Deceased

Hancock County Medical Society:
Higgins, Royal G., Bar Harbor, Maine. Died September 5, 1945.

Notices

1946 Annual Meeting

Dr. H. Clifford Loos of Los Angeles, one of the two owners of the Ross-Loos Medical Group, has accepted the invitation of Dr. Leighton to speak at the Annual Meeting of the Maine Medical Association at Poland Spring in June, 1946. Dr. Loos is making the trip East from California for this purpose alone, and the members do not want to miss this important event.

Erratum

Physicians as Metaphysicians

In the October issue of THE JOURNAL, page 168, the by-line for the above named article reads, "Julius Seelye Bixler, Colby College, Lewiston, Maine." It should read, Julius Seelye Bixler, Colby College, Waterville, Maine.

Medical Care—Airborne—Continued from page 190

"Captain Lorrimer M. Schmidt, 0505658, Medical Corps, for meritorious achievement during the period 1 June 1944 to 7 February 1945. As battalion surgeon, Captain Schmidt made an outstanding contribution to the physical welfare, morale and military efficiency of his unit. He thoroughly trained the aid men of his command and inspired them to a high sense of duty which reflected in highly efficient conduct during combat. Both in training and in combat, his professional skill and tireless efforts to care for his men despite personal risk and hardship, endeared him to all officers and men of the battalion. His outstanding conduct was clearly above and beyond the call of duty and in keeping with the highest traditions of the armed forces.

"By command of Major General Miley

W. K. Liebel,
Colonel, CSC,
Chief of Staff."

Editorial—Continued from page 192

civilian as well as federal, research and educational as well as purely clinical. Then he proposes:

"An analysis . . . should be made by a board appointed on the highest level. Its function should be limited to fact finding and recommendation. Its membership should be composed of both civilian and government medical and administrative personnel. The civilian component should represent educational and research as well as clinical interests, and there should be due representation from the major medical specialties. The government component should include the various branches of the armed services, the Veterans' Administration and the Public Health Service."

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Boothbay Harbor	St. Andrew's Hospital	1st Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Lewiston	Central Maine General	1st Monday
	St. Mary's General	2nd Monday
Portland	Maine Eye and Ear Infirmary	1st Wednesday
	Maine General	2nd Friday
	Mercy	3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters	2nd Tuesday
	Thayer	Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

The Journal
of the
Maine Medical Association

Volume Thirty-six Portland, Maine, December, 1945 No. 12

Accessible Malignancies of the Head

Thomas C. McCoy, M. D., Waterville, Maine

Malignant growths of the head are prone to early metastases, due to the proximity of the cervical lymph glands. Many cases go beyond the possibility of surgical relief before they are recognized.

The most common growths are around and in the mouth, because this locality is often subjected to chronic irritation.

I am sorry to say that our brethren in the dental field have not been taught to diagnose early malignancy. I have seen a large number of cases that came to a fatal termination because the dentist did not send them for surgical consultation early enough.

In general, any growth or sore place in the mouth or on the lips which persists should be seen by a competent physician.

How many malignancies I have seen from ill fitting false teeth, or constant irritation from jagged tooth edges. People should be taught that what they call a cold sore on the lip may be a cancer.

Those rough patches of broken skin can be an epithelioma. A small pigmented growth on the face which persons call moles can be melano sarcoma. Increasing difficulty in swallowing or breathing can mean cancer of the tonsil.

But the majority of all these cases, particularly the ones pronounced inoperable can be nicely treated by radiation properly handled. I shall take up in a sketchy manner the most frequent accessible malignancies of the head.

I do not consider cancer of the nasal accessary sinuses, nor osteo sarcoma of any part of the head as accessible. True many of these cases can be handled by radiation, but they come under another classification. Most of these cases demand surgery to make them accessible.

Cancer of the Tonsil

The gradual enlargement of one tonsil in patients of any age should be looked on with suspicion. The growth may or may not be accompanied by pain. Bear in mind, however, that about 17% of all tumors of the tonsil are benign, so a biopsy for diagnosis is imperative.

The most common form of tumor is the epitheliomas with lymphosarcoma in second position.

The most favorable cases for treatment are the basal cell type of tumors and the least favorable are the epidermoid types which unfortunately are the most frequent type found.

Malignant tumors of the tonsil tend to metastasize very early. Hence, the first symptom noticed by the patient may be enlargement of the anterior chain of cervical glands.

Fortunately almost all malignant tumors of the tonsil are peculiarly susceptible to radium, if treated early. Deep seated metasteses are a contra indication for radiation.

Treatment consists of the insertion of removable seeds of radon, plus deep X-ray where required.

Compiled statistics gathered from a résumé of the reports of 6 authorities shows 23% of cases free from symptoms 5 years after treatment by radiation.

About 49% of cases treated were alive and healthy one year after radiation.

Carcinoma of the Floor of the Mouth

Malignant growths of this location usually start in the fraenum of the tongue as a raised bluish white thickened irregular growth.

If not recognized early, involvement of the tongue may be the first symptom noticed by the patient.

The most common malignancy of the floor of the mouth is Epidermoid Carcinoma. Adenocarcinoma far less frequent, usually begins in the salivary glands.

Metastasis to the lymph glands is early. Most common glands involved are the submaxillary and submental glands.

As a general rule all growths of the floor of the mouth diagnosed as malignant are inoperable. Radiation is the only possible relief. Statistics show about 40% five-year cures in cases without palpable lymph glands. With metastatic lymph glands the result drops to 10%.

Cancer of the Cheek

When we speak of cancer of the cheek we always refer to a lesion inside the mouth on the cheek wall. Lesions which appear on the outside of the cheek are dermoid in character and are classified as such.

These tumors classify into two varieties. First: A whitish papillomatous lesion, extremely rapid in growth and free bleeding on touch.

Second, we have the ulcerative variety which has hard edges simulating the ulcer of syphilis but differing in that the hard edges infiltrate the cheek substance.

Both of these growths progress to metastesis very early. We seldom see a case in which surgery will avail.

These malignancies usually have no symptoms the patient can see or feel until ulceration takes place. When it does the patient may complain of pain; a hot food may cause sensation coming in contact with the lesion.

As the disease progresses pain becomes a constant symptom. It may become so severe that it interferes with speech or deglutition. Next a foul odor and discharge is noted, caused by breaking down of the cheek tissues.

In the later stages fistula may form causing the patient much discomfort by external discharge of saliva and detritus.

Metastasis occurs in three ways. It may take place by local invasion of the surrounding tissues by direct extension. Second, it may extend along the fascial planes. Third, it may either be carried by the blood or lymph streams. Thus in cancer of the cheek in the advanced stages distant metastasis are prone to occur.

When we undertake to treat these cases we first send them to the dentist and have all carious or rough teeth removed.

Statistics show that 39% of all cases of cancer of the cheek treated by radiation were alive and well at 5 years. 56% well after 3 years.

Cancer of the Lip

Cancer of the lip is divided into two distinct classes; the superficial and the infiltrating.

The first form is localized to the vermilion border and occurs either as a papillomatous tumor or as a superficial ulceration. These are the cases patients call obstinate cold sores.

The second class is made up of tumors that infiltrate the whole lip.

Many of these cases extend inward to the mucus membrane and many attack the bone of the jaw. Cancer of the lip is almost always squamous cell epithelioma.

These cases usually come to the physician because of lymphatic invasion. Many of these cases respond to surgery if a radical operation is performed. Post operative radiation however is advised.

Radiation alone on the other hand can cure this disease with a minimum loss of normal tissue, hence less deformity.

Most authorities agree that early radiation is

the treatment of choice in all lip cancers. Authorities agree that 85% of all lip cancers are reported cured after 5 years if taken before extension into the cervical glands.

66% of all cases, including large tumors and where there was metastasis can be cured by proper radiation.

Cancer of the Tongue

Neoplasms in this organ are found in any location but are most frequent on the sides and tip of the tongue.

Early pain is characteristic. Patients complain early of hot or spicy foods. Many tell you the whole tongue feels swollen when visually it is not. Some cases complain of anaesthesia of half of the tongue.

These tumors are usually of two types. First is squamous cell epithelioma which is far the most common. The second class are transitional cell epithelioma.

The tumor may have the appearance of a benign wart. Or it may be a large papillomatous mass. It may first manifest itself as an ulcer or fissure. Or we may have thickening of the entire tongue, from tip to base.

Glandular involvement from malignancies of the tongue occurs early. The submaxillary and suprahyoid glands being the first involved.

Treatment of choice radiation. The advantages of this treatment are four in number.

(1) Local anaesthesia only needed.

(2) Produces no mutilation.

(3) The function of the tongue is preserved.

(4) Results compare most favorably with surgery.

Statistics show in figures cases without lymph glands, 55% 5 year cures. Grouping all cases together 28% can be cured by radiation.

Dermoid Cancer of the Face

Lend themselves admirably to radiation. Patients usually consult a physician before ulceration because the lesion is in plain view.

As a rule the patient complains of little pain. Burning and itching are most bitterly complained of.

The growth may be a simple scaling of the skin or it may be raised above the surface.

Tendency to develop into melanoma is grave.

Treatment is by plaques strapped on to deliver proper radiation.

Statistics show 92% 5 year cures by this method.

It is an accepted fact that any case of malignancy that is treated, and which at the end of 5 years is alive and free from any symptoms, is called a 5 year cure.

General

Almost all accessible cancers of the head can be successfully treated by radiation.

Cases given up by the surgeon can in many instances be what we call 5 year cures. By radiation we mean the use of radon followed where necessary by deep X-ray therapy.

In regard to biopsies. Valuable wherever the patient agrees, but must be used with caution.

Biopsies around the mouth spread the disease like wild fire. Unless you can get a rapid report start radiation before you get it to stop the spread.

In cases where there is lymphatic invasion, should always be followed up by X-ray.

Saving humanity is a physician's first duty. If we will pay more especial attention to small growths or sore places around the head we will go far along the right road.

The proper treatment of living cases of tuberculosis is fortunately also the humane, the scientific, and the effective method for its prevention. The proper care of the sick secures the protection of the well.—Homer Folks, 6th Inter. Tuber. Congress, Sept., 1908.

The family physician occupies the key position in finding tuberculosis. He, in the final analysis, plays the most important part in the reduction of tuberculosis because the control of the disease begins in his office.—L. M. Morse, M. D., *Wisc. Med. Jour.*, March, 1941.

Paroxysmal Ventricular Tachycardia

REPORT OF A CASE

Melvin Bacon, M. D., Sanford, Maine

Ventricular tachycardia is comparatively uncommon. Its occurrence is most frequent in older individuals. Moreover, its presence usually indicates severe heart disease but occasionally it occurs in seemingly normal individuals.[1] The following is a case report of this condition associated with extensive cardiac pathology. Because of the appearance of paroxysmal ventricular tachycardia at the time of recording the electrocardiogram it appeared of interest to report this case.

Case History

Mrs. B. B., age 59, was first seen on January 15, 1944, because of palpitations, nervousness and bad cold. Her illness began 4 weeks before when she states she had an attack of the "flu." At this time she had fever and pain in her muscles and joints, cough and expectoration. The fever and pains subsided after a few days, but the cough and expectoration have persisted intermittently up to the present. Three weeks after the onset of the "flu" she began to have palpitations of varied intensity and became increasingly nervous. She lost 6 pounds during this time, was tired continually and had some shortness of breath.

Her past history revealed diphtheria at the age of 6. A husky voice has persisted since this. A tumor of the uterus was removed in 1920. The family history and marital history are non-contributory.

She has had no menses since her operation at age 36.

Physical examination revealed a well developed and nourished 59-year-old white female who was coöperative but nervous and in no apparent distress. Her height was 65 inches and weight 154 pounds. Her pulse was 58, but irregular. The blood pressure was 130/60. The general physical examination was negative aside from the cardiac findings. Examination of the heart revealed the apex beat in the 6th space 14 cm. to the left of the midsternal line. Diameter at the base was 7 cm. The rhythm was irregular with frequent extra systoles and there was a harsh grade III systolic murmur heard best at apex and a grade II at the aortic area.

Laboratory Data

The urine was negative. The hemoglobin was 97%, the red blood count was 4,280,000, the white blood count was 7,000 and the differential was normal. The Hinton and Widal was negative. An X-ray of the chest was negative for pulmonary disease. Fluoroscopy showed the aorta to be tortuous and pulsating and the left ventricle large. The transverse diameter by orthodiagram was 130 mm. The average diameter for a woman of her height and weight would be 120 mm.

Electrocardiogram, 4 leads taken on January 27, 1944, are illustrated in Chart I.

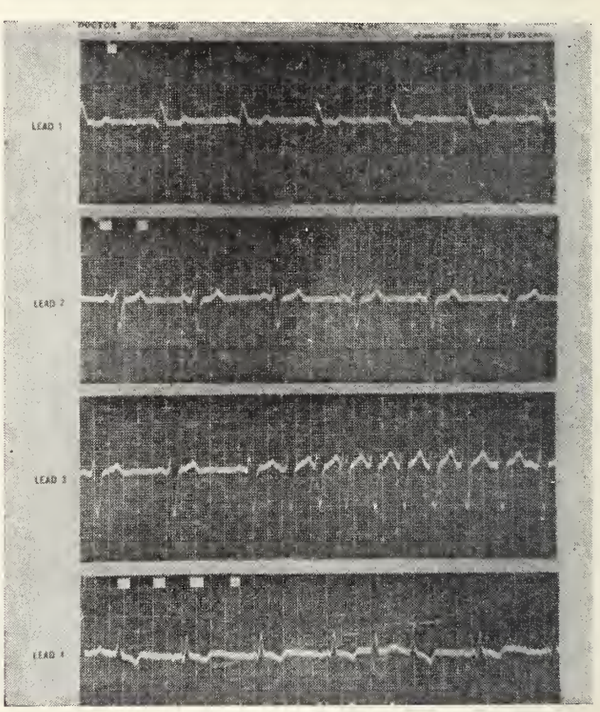


Chart I

They showed an arrythmia incident to extra systoles of ventricular origin which may be

seen in runs up to seven in Lead III. The P wave and P-R interval are not remarkable. The QRS complex is wide (.13 sec.) and slurred. There is no isoelectric RS-T segment. The T is inverted in Lead IV and is of the coronary type. Left axis deviation is also present.

A second set of tracings taken September 9, 1944, are shown in Chart II.

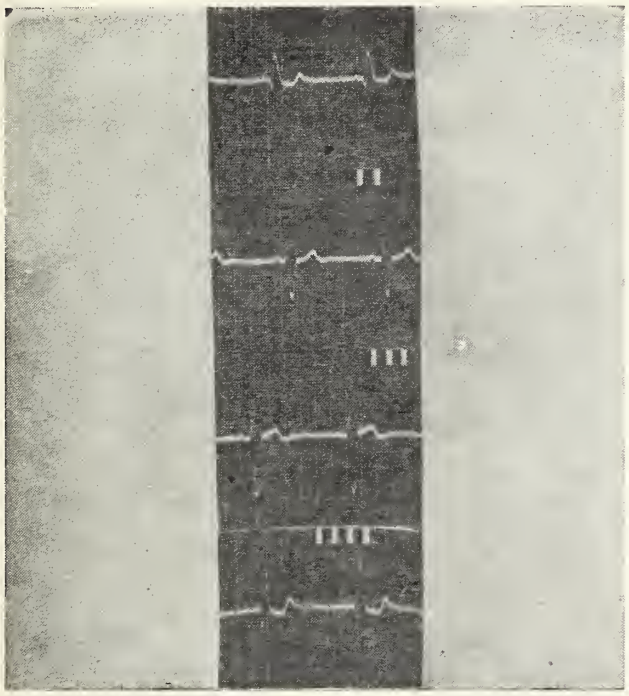


Chart II

They revealed a normal rhythm with an occasional ventricular premature beats. The rate is 48. The P wave and P-R interval are within normal limits. The duration of the QRS complex is .14 sec. which is markedly prolonged. There is a broad slurred R wave in Leads I and IV and a broad slurred S wave in Leads II and III.

These electrocardiograms indicate extensive cardiac damage. There is evidence of paroxysmal ventricular tachycardia with left branch bundle block, an extra systolic arrythmia, coronary pathology, myocardial damage and left axis deviation. The ventricular tachycardia appears to be on a basis of coronary pathology.

Prognosis

It would appear that the prognosis is poor in view of the presence of paroxysmal ventricular tachycardia and coronary disease. White[3] states that paroxysmal ventricular tachycardia must be considered serious until proved unimportant. The possibility of ventricular fibrillation is ever present. However, 19 months have elapsed and she is feeling better than ever. She is less nervous and has had only a rare palpitation.

Treatment

She was started on quinidine sulfate, three grains, three times daily, with the idea of reverting the heart back to normal rhythm and eliminating the ventricular extra systoles. Eggleston[3] has suggested that the administration of quinidine in adequate doses in anticipation of the development of a ventricular tachycardia may prevent an attack. Levine[4] is of the opinion that quinidine is almost a specific for a case of this sort and that in most cases will restore normal rhythm. However, this drug had to be stopped after two days because the patient complained of ringing in the ears, dizziness and a sensation of nausea. She is now receiving one tablet of vitamin B complex twice daily, ten milligrams of thiamine hydrochloride three times a day and a half grain of phenobarbital three times daily. She has not had an attack of tachycardia for about a year and feels very well except for some nervousness. All her symptoms related to the heart have disappeared.

Conclusion

This paper presents a case report of paroxysmal ventricular tachycardia associated with extensive cardiac pathology. The occurrence of the tachycardia at the time of recording the electrocardiogram appears to make it of interest to report this case. It is possible the infection "flu" might have been a precipitating cause of the paroxysmal ventricular tachycardia.

References

1. Christian, H. A.: Osler's Principles and Practice of Medicine, ed. 15, New York and London, D. Appleton-Century, 1944, p. 1007.
2. White, P. D.: Heart Disease, ed. 3, New York, MacMillan & Co., 1945, p. 872.
3. Conference on Therapy: Disorders of cardiac rhythm, *J. A. M. A.*, 112: 322-27, Jan. 28, 1939.
4. Levine, S. A.: Clinical Heart Disease, ed. 3, Philadelphia, W. B. Saunders Company, 1945, p. 349.

The President's Page

To the Members of the Maine Medical Association:

One of the tragedies of war is the havoc Tuberculosis has played with the health of people of countries engaged in armed conflict. Mental strain and physical privations, such as inadequate supplies of food and crowded living conditions, have left men, women, and, especially, children an easy prey to the ravages of disease.

Tuberculosis has followed in the wake of past wars, taking a tremendous toll among weakened populations.

The United States has apparently held its own against this disease during the four years of war. While the 1944 tuberculosis death rate,— the latest available,— showed continued decline for the nation as a whole, preliminary figures indicate a substantial increase in certain states.

Expansion and intensification of the work of the National Tuberculosis Association and its affiliates, in coöperation with the U. S. Public Health Service, are necessary to hold the gains already made.

There is no place for complacency regarding tuberculosis in this country. Let us take an interest in this present day Thirty-ninth Annual Christmas Seal Sale sponsored by the Maine Public Health Association. It is a worthy and most important activity, and should have our whole-hearted support. Let's pass the word along.

Adam P. Leghton, M. D.,
President, Maine Medical Association.

Editorial

A. M. A. Trustee Tells Why U. S. Doctors Oppose Regimentation

Says Federal Plan Is Un-American And Expensive, Tending To Encourage Quantity Instead Of Quality

In an article dealing with medical care for the American people, Louis H. Bauer, M. D., Hempstead, N. Y., member of the Board of Trustees of the American Medical Association, wrote in the December 1 issue of *The Journal:*

"We are concerned with a problem on which there are sharp differences of opinion. In fact, were there not these differences of opinion there would be no problem.

"As to the ultimate aim we are all agreed. I believe no one can quarrel with the platform of the American Medical Association, adopted in June, 1944, which calls for 'availability of medical care of a high quality to every person in the United States.' The differences of opinion arise as to how this aim is to be achieved.

"As doctors we see the problem in a way no one else can possibly see it. It pertains to our daily work and we are naturally closer to it than any one else. One does not consult a doctor if one wishes to draw up a will. One goes to a lawyer. Neither does one consult a lawyer if one wishes to build a house. One goes to an architect. Yet there are many who think it is not necessary to consult the doctors on any problems related to medical care but that legislators, those engaged in social welfare and other laymen can draw up a complete program, have it adopted and then expect the doctors to make it work. It should be borne in mind that, no matter what system is eventually evolved in this country for delivering medical care, the doctor is the one who is going to have to deliver it. It cannot possibly be delivered by a 'social uplifter.' Hence it would be better for all concerned if the plan adopted is one which will enlist the coöperation and enthusiasm of the medical profession.

"Another point usually lost sight of is that the mere delivery of a quantity of medical care is not solving the problem. The homeopathic precept that the more a thing is diluted the greater its effectiveness went into the discard long ago. What we want is not just more medical care but more medical care of a high quality.

"The answer to any complex problem is usually not simple but also complex. So, in our problem of medical care, the answer is not a single one but a multiple one. Yet the Social Security Board and Senators Wagner and Murray and Congressman Dingell refuse to admit there is any possible answer but the single one of a national compulsory sickness insurance, regardless of the fact that nowhere has it been as satisfactory as our own system of private medical care.

"A careful analysis of the situation would seem to indicate that there are certain elemental factors which are responsible for our problem. These factors are (1) improper distribution of doctors, (2) lack of proper diagnostic facilities in certain areas, (3) the costs of illness — particularly so-called catastrophic illness — and (4) a general economic factor. These factors are closely related and cannot be considered separately. Why are certain areas devoid or short of doctors? There are two reasons. One is that certain areas are so sparsely settled that there is no attraction for a doctor, not only because he will have insufficient patients, but because there are no educational or social facilities for him to bring up his children. The other is really the second factor (namely, the lack of proper diagnostic facilities) so that he cannot practice good medicine. In the latter case he either leaves or else he does what to my mind is worse, he stays and practices poor medicine. With further reference to the lack of diagnostic facilities, this lack is usually because the community by itself cannot support the necessary facilities.

"The third factor, the costs of illness, again is tied up partially with the second: availability or nonavailability of proper diagnostic facilities. The high cost of illness is not in ordinary intercurrent illness but in the cost of diagnosis in the more complicated illnesses, in hospitali-

ation and in private nursing care. Also in sparsely settled areas the long distances a doctor may have to go increase the cost of his services. Still another important reason is the cost of care of the chronic invalid.

"The fourth factor, the general economic one, is the matter of housing, clothing, nutrition and sanitation. This is a social problem of the community and not a medical problem, although the neglect of it results in an increase in the prevalence of disease and the necessity for medical care. The solution, however, is not the pouring in of medical care but preventing the necessity for it."

Commenting on various phases of the program, Dr. Bauer said:

"Prevention of disease by inoculation and curing disease in its early stages are excellent, but it must be remembered that good living conditions, including good nutrition, housing and sanitation, are equally important. . . .

"The American Medical Association would extend voluntary plans and has approved the principle of so-called medical service plans for the medically indigent. . . .

"The American Medical Association has recommended the use of the voluntary insurance principle in the hospitalization as well as the medical care of the indigent. . . .

"It is recommended that the medical care of veterans be integrated into these voluntary plans of hospitalization and medical care. . . .

"The medical profession, under certain conditions, approves appropriations by Congress of funds for medical purposes. It feels, however, that in many instances states have sought aid and appropriations for such functions without any actual financial need on the part of the state, in order to secure such funds as might be available. Funds may be allotted when proof is given of the actual financial need by the state for prevention of disease, for promotion of health or for the care of the sick. Health is primarily a local responsibility. Physicians should be integrated into the control of all medical affairs, and the control of local projects should be local in character. . . .

"There should be continuous surveys of the manner in which existing provisions meet existing needs in order to permit progress. There should be continuous evaluation of medical services so that they may be kept up to the best that can be provided. . . .

"To attract physicians to rural areas there must be adequate diagnostic facilities, and in some cases subsidies may be necessary. . . .

"We are unalterably opposed to the Wagner-Murray-Dingell bill for the following reasons: It is un-American; it is inordinately expensive, involving an 8 per cent payroll tax up to $3,600 of income, and this probably inadequate. In fact, a recent economic survey indicates that with a national income of $120,000,000,000 a 15 to 17 per cent tax will be necessary and even this, perhaps, inadequate. It sets up another federal bureaucracy with a lay board—the Social Security Board—at its head, to decide all medical matters, and although the administrative head is the Surgeon General, who incidentally usually is, but need not by law be, a physician, nevertheless he is an appointive, not an elective, official and he is subject to the dictates of this lay board; a third party, namely the government, is brought between the doctor and the patient, and the doctor is responsible to that third party. . . .A poor type of medical care is encouraged—quantity without regard to quality. Inefficiency, red tape and political medicine will result. Should the bill be enacted, government control would cover not only doctors but eventually dentists, nurses, technicians, hospitals, medical and hospital supplies and equipment. Notwithstanding Senator Wagner's claim that this bill is not socialized medicine, it is just that. It is paternalistic and inevitably will lead to national socialism."

The large number of cases of tuberculosis in the later age groups represents an accumulation which started in adolescence and early adult life.—J. Burns Amberson, Jr., M. D.

A tuberculin reaction provides invaluable information, for it furnishes the trail which one may often trace to previously unknown and wholly unsuspected sources of infection. —J. A. Myers, M. D., *Amer. Rev. of Tuber.*, February, 1941.

Necrologies

Sullivan L. Andrews, M. D.,
1877-1945

Sullivan L. Andrews, M. D., 68, Ophthalmologist and Otolaryngologist in Lewiston since 1914, died in a Lewiston hospital, November 26, 1945.

He was born in Paris, Maine, August 7, 1877, the son of Alfred P. and Ada M. Lane Andrews. He was graduated from Westbrook Seminary, and from Bowdoin Medical School in 1901. He practiced at Clinton, Maine, nine years, and attended the New York Post Graduate Medical School and Hospital one year, before locating in Lewiston.

Doctor Andrews was a member of the Androscoggin County Medical Society, the Maine Medical Association, and the American Medical Association, and a Fellow of the American College of Surgeons. He was a former president of the Central Maine General Hospital staff, on which he served from 1915 until retirement in 1939.

His widow and two sons survive.

William R. Needelman, M. D.,
1895-1945

William R. Needelman, M. D., practicing physician in Portland, Maine, twenty-two years, died Thursday, November 22, 1945, in Mercy Hospital of a heart attack.

He was born in New York City, December 6, 1895, the son of the late Max and Anna Needelman. He moved to Portland in his early youth, attended the local schools being graduated from Portland High School in 1914, from Bowdoin College in 1918, and from Yale Medical School in 1923.

In 1918, he left Bowdoin to enlist in the Allentown Unit, composed of Portland men, and remained with the unit until it disbanded after the Armistice. He was commissioned a first lieutenant in the 240th Coast Artillery, Maine National Guard, in 1937, and was called to active duty with that regiment in September, 1940, with the rank of Captain. A year later, he was discharged because of ill health. Doctor Needelman was a member of the staff at the local induction station from its inception until his death.

He started practice in Portland in 1923 following his internship at the Maine General Hospital. He was a member of the staff of the Mercy Hospital and the former State Street Hospital. He was on the Medical Staff of the Jewish Home for the Aged, and was a county medical examiner several years.

Doctor Needelman was a member of the Portland Medical Club, the Cumberland County Medical Society, the Maine Medical Association, and the American Medical Association.

A brother and two sisters survive.

George W. Upton, M. D.,
1865-1945

George W. Upton, M. D., 80, practicing physician at Sherman, Maine, fifty-three years, died in the Madigan Memorial Hospital, November 23, 1945.

He was born at Sheffield, N. H., July 26, 1865, the son of David H. and Mary A. McLaughlin Upton, and was graduated from Dartmouth Medical School in 1887. He later studied at the New York Post Graduate Medical School and Hospital, and at the University of London Hospital.

He was a member and past president of the Aroostook County Medical Society, a member of the Maine Medical Association and the American Medical Association.

In June, 1937, he was presented with the Maine Medical Association's fifty-year service medal, and made an Honorary Member of the Association.

A daughter, and three grandchildren, survive.

COUNTY SOCIETIES

Androscoggin
President, Romeo A. Beliveau, M. D., Lewiston
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Fort Fairfield

Cumberland
President, Henry P. Johnson, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Thomas C. McCoy, M. D., Waterville
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Francis A. Winchenbach, M. D., Bath
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Samuel S. Silsby, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Ralph C. Stuart, M. D., Guilford
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, John F. Hanson, M. D., Machias
Secretary, John Young, M. D., Jonesport

York
President, Harry L. Prescott, M. D., Kennebunkport
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Cumberland

A meeting of the Cumberland County Medical Society was held at the Mercy Hospital, Portland, Maine, on November 19, 1945, with Dr. Henry P. Johnson presiding. A clinic was held at this hospital at 5.00 P. M., after which an excellent steak dinner was served.

The business meeting began at 8.00 P. M. A communication and resolution adopted by the Wayne County Medical Society of Michigan was read. The purpose of this resolution was to urge all medical societies to instruct their delegates to act favorably in the establishment of a General Practice Section in the American Medical Association at their next annual meeting. A motion to so instruct our delegates was made by Dr. Frank A. Smith, and was carried unanimously by the society. Drs. Jerome W. Bergman, Charles R. Glassmire, and William E. Freeman were unanimously elected to membership in the society.

Dr. Adam P. Leighton, President of the Maine Medical Association, was called upon and spoke briefly regarding the next meeting of the Maine Medical Association, mentioning some of the various speakers who have signified their intention of attending this meeting. He also spoke regarding insurance plans, and medical schools in Maine, about which he offered a further explanation at some later date.

The speaker of the evening was Dr. Ethan Allen Brown, M. R. C. S., London, L. R. T. T., England, and now a member of the staff of the Pratt Diagnostic Clinic in Boston. His subject was *A New Antiseptic and Its Evaluation.* He gave an interesting outline of the characteristics of both ancient and modern antiseptics and described in greater detail a newer antiseptic with which he has had considerable recent experience. This antiseptic is called "Thenardol", and is composed of urea peroxide in glycerol, to which has been added 8-hydroxiquinone in a 1-1000 dilution. Experimentally this solution gives uniform results when tested in vitro on most bacteria, and it has been successfully used in a number of mouth infections, skin infections, stubborn varicose ulcers, and empyema cavities. Investigation of this antiseptic is still in the process, and while its author does not attempt to substitute it for many of the bacteriacidal agents in use it does offer a supplemental mode of treating certain other types of infection.

JOSEPH E. PORTER, M. D.,
Secretary.

Hancock

A meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, on Wednesday evening, November 14, 1945.

It was voted that the President and Secretary draw up a set of resolutions on the death of B. Lake Noyes, M. D., of Stonington; one set to be fixed permanently to the records of the society and the other sent to Mrs. Noyes.

It was voted to sponsor the notice of return of medical veterans to their practices.

It was voted to instruct the delegate to the Maine Medical Association that our society was in favor of the establishment of a General Practice Section in the American Medical Association.

Carl W. Ruhlin, M. D., of Bangor, talked on *Low Back Pain.* He had numerous slides to illustrate

points in his subject matter. A general discussion period followed Doctor Ruhlin's talk.

J. H. Crowe, M. D.,
Secretary.

Kennebec

Following dinner at the Gardiner General Hospital, Gardiner, Maine, at 6.30 P. M., October 25, 1945, the President, Dr. T. C. McCoy, presided over a meeting of the Kennebec County Medical Society. The minutes of the May meeting were read and approved. Dr. Ella Langer, of Augusta, a graduate of the University of Vienna, Austria, in 1920, who has lived in Maine since September 18, 1944, was elected to membership in the Society. It was decided to hold no meeting during November because of the nearness of Thanksgiving, and to hold the December, or annual meeting, at the Augusta State Hospital on invitation of Dr. F. C. Tyson. In-as-much as it is customary to elect officers at the annual meeting the President appointed a nominating committee to bring in a slate of officers for 1946.

The speaker of the evening was Dr. Adam P. Leighton, President of the Maine Medical Association, who spoke on *Charlatans, Insurance, and a Medical School in Maine.* Dr. Edward L. Herlihy, of Bangor, opened the discussion on the medical school in Maine. His remarks were followed by free discussion from the floor.

Clair S. Bauman, M. D.,
Secretary.

Oxford

The annual meeting of the Oxford County Medical Society was held at Bethel Inn, Bethel, Maine, Wednesday afternoon and evening, October 24, 1945. The meeting was called to order by the President, Dr. H. Louella Noyes. Minutes of the previous meeting were read and accepted. The report of the Secretary-Treasurer was read and accepted.

The following Officers were elected for the ensuing year:

President, Harold W. Stanwood, M. D., Rumford.

Vice President, Harry W. Wilson, M. D., Bethel.

Secretary-Treasurer, James S. Sturtevant, M. D., Dixfield.

Councilors: R. E. Hubbard, M. D., Waterford (one year); Lester Adams, M. D., Hebron (two years); H. Louella Noyes, M. D., Rumford (three years).

Delegates to the 1946 annual meeting of the Maine Medical Association: R. R. Tibbetts, M. D., Bethel (one year); D. M. Stewart, M. D., South Paris (two years). Alternates: C. W. Nelson, M. D., Norway (one year); Lester Adams, M. D., Hebron (two years).

Dinner at 7.00 P. M., was followed by an address by Dr. Adam P. Leighton, Portland, President of the Maine Medical Association. Doctor Leighton spoke on Insurance and the possibility of re-establishing a Medical School in Maine.

Members of the society were pleased to have the following guests present: Dr. Leighton; Dr. Frederick R. Carter, Portland, Secretary-Treasurer of the Maine Medical Association; and Drs. Wallace E. Webber, Wedgwood P. Webber, and E. C. Higgins, all of Lewiston.

Attendance was 44.

J. S. Sturtevant, M. D.,
Secretary.

Penobscot

The annual meeting of the Penobscot County Medical Association was held at the Bangor House, Bangor, Maine, Tuesday, November 20, 1945.

The Secretary reported a membership of 85; Active Members and Members in Military Service 82, Honorary Members 3. During the past year one member was lost by death, Eugene B. Sanger.

Eight meetings have been held during the past year with an average attendance of 38, a slight decrease from the previous year.

The Treasurer's report showed a small balance.

Officers for the year 1945-46 were elected as follows:

President, George B. Weatherbee, M. D., Hampden Highlands.

Vice President, Edward L. Herlihy, M. D., Bangor.

Secretary-Treasurer, Forrest B. Ames, M. D., Bangor.

Board of Censors: J. J. Pearson, M. D., Old Town; J. E. Whitworth, M. D., Bangor; W. J. Comeau, M. D., Bangor.

Delegates to the 1946 annual meeting of the Maine Medical Association: Ernest T. Young, M. D., Millinocket; Martyn A. Vickers, M. D., Bangor; John E. Smith, M. D., Bangor; Lawrence M. Cutler, M. D., Bangor. Alternates: Asa C. Adams, M. D., Orono; FaLorest J. Wright, M. D., Bangor; Clarence Emery, Jr., M. D., Bangor.

Resolutions were accepted on the death of Doctor Sanger.

It was voted that a home-coming party be given to the members returned from the Armed Services.

It was voted that the Delegate of the Maine Medical Association to the House of Delegates of the American Medical Association be informed that the Penobscot County Medical Association were in favor of the Michigan State Medical Society resolution asking for the formation of a General Practice Section in the American Medical Association.

Joseph Memmelaar, of Brewer, a former member, was voted a member of the Penobscot County Medical Association. Doctor Memmelaar has opened an office in Bangor for the special practice of Urology and Genito-Urinary Surgery.

The speaker of the evening was Lawrence M. Cutler, Major, M. C., who gave a most interesting description of *Experiences in the South Pacific.*

Attendance was 42.

Forrest B. Ames, M. D.,
Secretary.

Piscataquis

A meeting of the Piscataquis County Medical Association was held at the Blethen House, Dover-Foxcroft, Maine, November 23, 1945. After a delicious steak dinner the regular business meeting was held.

It was voted that the next meeting be held at Doctor Merrill's residence in Dover-Foxcroft on February 24, 1946, this being Doctor Merrill's birthday.

The speaker of the evening was Wilfred J. Comeau, M. D., of Bangor, who gave an interesting talk on his experiences while in the Army.

All members who were present paid their dues for 1946. In spite of this a pleasant evening was enjoyed by all.

Norman H. Nickerson, M. D.,
Secretary.

New Members

Cumberland

Jerome W. Bergman, M. D., Portland, Maine.
William E. Freeman, M. D., Yarmouth, Maine.
Charles R. Glassmire, M. D., Portland, Maine.

Kennebec

Ella Langer, M. D., Augusta, Maine.

Penobscot

Joseph Memmelaar, M. D., Brewer, Maine.

Members Released from Military Service

Androscoggin County Medical Society:

Beeaker, Vincent,	Lewiston
Clapperton, Gilbert,	Lewiston
Cox, William V.,	Auburn
Greene, Merrill S. F.,	Lewiston
Steele, Charles W.,	Lewiston
Tibbetts, Otis B.,	Auburn
Webber, Wedgwood P.,	Lewiston

Aroostook County Medical Society:

Toussaint, Leonid G.,	Fort Kent

Cumberland County Medical Society:

Blaisdell, Elton R.,	Portland
Casey, William L.,	Portland
Dunham, Carl E.,	Portland
Finks, Henry B.,	Portland
Greco, Edward A.,	Portland
Heifetz, Ralph,	Portland
Holt, C. Lawrence,	Portland
Johnson, Albert C.,	Portland
Johnson, Gordon N.,	Portland
Love, Robert B.,	Gorham
Moore, Roland B.,	Portland
Morrison, Alvin A.,	Portland
Schwartz, Carol,	Portland

Franklin County Medical Society:

Brinkman, Harry,	Farmington
Reed, James W.,	Farmington

Hancock County Medical Society:

Weymouth, Raymond E.,	Bar Harbor

Kennebec County Medical Society:

Bull, Frank B.,	Gardiner
Fay, Thomas F.,	Augusta
McWethy, Wilson H.,	Augusta
Murphy, Norman B.,	Augusta
Shelton, M. Tieche,	Augusta
Towne, Charles E.,	Waterville

Knox County Medical Society:

Lawry, Oram R., Jr.,	Rockland

Oxford County Medical Society:

Howard, Henry M.,	Rumford
Wilson, Harry M.,	Bethel

Penobscot County Medical Society:

Feeley, J. Robert,	Bangor
Pressey, Harold E.,	Bangor
Smith, John E.,	Bangor
Witte, Max E., Jr.,	Falmouth Foreside

Piscataquis County Medical Society:

Nickerson, Norman H.,	Greenville

York County Medical Society:

Cobb, Stephen A.,	Sanford
Gould, George I.,	Auburn
Murphy, John J.,	Wells Beach

The above listed names of Members Released from Military Service have been received by the Secretary of the Maine Medical Association as of November 30, 1945. Additional names, when reported to the Secretary, will be added to this list in future issues of the JOURNAL.

Notices

American Board of Ophthalmology

Important Announcement

Due to transportation difficulties the examination of the Board, originally scheduled for Los Angeles, January 28th to 31st has been changed to San Francisco, June 22nd to 25th, inclusive, 1946.

1946 Examinations: Chicago, January 18th through 22nd; New York, April, approx. 10th through 13th; San Francisco, June 22nd through 25th; Chicago, October 9th through 12th.

Officers, 1946: Chairman, Edward C. Ellett, Memphis; Vice Chairman, Georgiana D. Theobald, Oak Park, Ill.; Secretary-Treasurer, S. Judd Beach, Portland, Maine; Assistant Secretary, Theodore L. Terry, Boston; Consultant, Walter B. Lancaster, Boston.

List of Surgery: A new ruling requires that previously accepted candidates mail their lists of surgery to the Board office at least sixty days prior to their examination. All new applicants are now required to send their list with application.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Joseph E. Porter, M. D.*

Waterville: *Sisters Hospital*
1st and 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd and 4th Thursdays, 10.00 A. M.
Director, *A. H. McQuillan, M. D.*

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Rockland, Rumford, Sanford, Waterville, Wilton, Millinocket, Old Town, Portland, Presque Isle, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.

Your Membership Expires December 31st

Pay Your 1946 State and County Dues Promptly to your County Secretary

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Boothbay Harbor	St. Andrew's Hospital	1st Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Lewiston	Central Maine General	1st Monday
	St. Mary's General	2nd Monday
Portland	Maine Eye and Ear Infirmary	1st Wednesday
	Maine General	2nd Friday
	Mercy	3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters	2nd Tuesday
	Thayer	Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

Book Reviews

"Total War and the Human Mind"

A Psychologist's Experience in Occupied Holland

Author: Major A. M. Meerloo, M. D., F. R. S. M.

Published by: International Universities Press, New York, 1945. 78 Pages. Price, $1.75.

This informative little volume is written by a Dutch physician who for two years worked in a large clinic in occupied Holland. In addition to his medical work there was counseling to be done for every kind of difficulty and the author's interest in social psychology and psychiatry make his findings a contribution to the important body of literature on morale. Of special interest to his fellow members of the medical profession are his observations in regard to the psychosomatic affects of total war. In a chapter on "How the Body is Affected by Fear," Major Meerloo classifies the various types of reaction to fright. Changes in the vascular system he interpreted as in part substitutes for flight and in part mobilization for defence. He found that in times of anxiety, people became more susceptible to pain and, "Even Chronic arthritis made its appearance as an outlet for chronic fear."

Major Meerloo has some timely words of warning to a world which continues to live under the shadow of fear. He describes the vicious circle in which "fear inspires aggressiveness, aggressiveness brings a sense of guilt, and guilt seeks an outlet in more aggressiveness;" and his prescription is that only the fundamental instinct of self-preservation can arrest a headlong rush to destruction. The atomic bomb gives an added urgency to his wise suggestions on how the spiritual disintegration which has followed other wars can be prevented.

"Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1944"

Cloth. Price, postpaid, $1.00—Pp. 238. Chicago: American Medical Association, 1945.

The Council on Pharmacy and Chemistry recently issued the thirty-sixth edition of the Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association. This volume contains in compact form not only the reports of the Council which have been published in THE JOURNAL during the past year but also some additional reports which were not considered of sufficient importance to be published in THE JOURNAL.

The present volume is quite unusual in that it contains not one report concerning a product found unacceptable. However, there are five reports on the omission of products from New and Non-official Remedies, mainly for the reason that they have outlived their usefulness, and in most cases the manufacturers have expressed their lack of desire for continued inclusion of their brands.

This volume is a veritable mine of information on subjects of general interest to the physician, pharmacist and the pharmaceutical manufacture. The reports concern deliberations of the Council on general subjects ranging from the use of the Electron Microscope to the appraisal of new drugs. The report on Pathogenic Bacteria, Rickettsias and Viruses as shown by the Electron Microscope is noteworthy as being pioneer work in this field. The report on the Current Status of Prophylaxis by Hemophilus Pertussis Vaccine was prefatory to the acceptance by the Council on various brands of pertussis vaccines and pertussis vaccine combinations. The valuable and highly informative article on Local Treatment of Thermal Cutaneous Burns reports on the latest and best work in this field.

"New and Nonofficial Remedies, 1945"

Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1945

Cloth. Price, postpaid, $1.50. Pp. 760. Chicago: American Medical Association, 1945.

Each year a revised list of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association as of January first is published in book form under the title of "New and Non-official Remedies." The book contains the descriptions of acceptable proprietary substances and their preparations, proprietary mixtures if they have originality or other important qualities, important non-proprietary non-official articles, simple pharmaceutical preparations, and other articles which require retention in the book.

Some fifteen or twenty newly accepted preparations appear in the 1945 volume. A large number of preparations have been omitted, mainly brands of official preparations. The general statement concerning these pharmacopeial preparations has been retained for the information of physicians.

As stated in the preface, the entire book has been scanned to bring it up to date with the latest medical knowledge. It is noted that the section "Articles and Brands Accepted by the Council But Not Described in N. N. R.," a vestigial remnant of which appeared in the 1944 volume, has now entirely disappeared.

One is struck by the large amount of medical information contained in this volume. Certainly no other compendium of comparable price contains so much.

Index

VOLUME THIRTY-SIX

THE JOURNAL

of the

MAINE MEDICAL ASSOCIATION

Officers of the Maine Medical Association

1945-1946

OFFICERS

President, Adam P. Leighton, M. D., Portland
President-Elect, John O. Piper, M. D., Waterville
Secretary-Treasurer, Frederick R. Carter, M. D., Portland
Assistant Secretary, Esther M. Kennard, Portland

COUNCILORS AND DISTRICTS

First District,	Cumberland, York	Waldron L. Morse, M. D., Springvale,	1948
Second District,	Androscoggin, Franklin, Oxford	Ralph A. Goodwin, M. D., Auburn,	1948
Third District,	Knox, Lincoln, Sagadahoc	C. Harold Jameson, M. D., Rockland,	1947
Fourth District,	Kennebec, Somerset, Waldo	Roland L. McKay, M. D., Augusta,	1947
Fifth District,	Hancock, Washington	Harold S. Babcock, M. D., Castine,	1946
Sixth District,	Aroostook, Penobscot, Piscataquis	Forrest B. Ames, M. D., Bangor,	1946

CHAIRMEN OF COMMITTEES

Scientific
Ralf S. Martin, M. D., Portland

Medical Education and Hospitals
D. Allan Craig, M. D., Bangor

Medical Advisory
Allan Woodcock, M. D., Bangor

Legislative
Frederick R. Carter, M. D., Portland

Public Relations
Frederick T. Hill, M. D., Waterville

Cancer
Julius Gottlieb, M. D., Lewiston

Social Hygiene
Oscar R. Johnson, M. D., Portland

Publicity
Frederick R. Carter, M. D., Portland

INDEX

Volume Thirty-six

Guide

Articles

Authors

Editorials

General

Necrologies

Its remarkable ability to stimulate the heart and increase cardiac output, raise the blood pressure, constrict the peripheral arterioles, dilate blood vessels of voluntary muscles, and relax bronchial muscles . . . makes ADRENALIN one of the most *versatile* and *useful* therapeutic agents at the command of the physician. Little wonder, then, that it's always kept close at hand in operating room, office, and medical bag.

To permit full use of its many therapeutic applications, there is a form of ADRENALIN (Epinephrine) to meet every medical need: Solutions of 1:100, 1:1000, 1:2600, 1:10,000; Suspension of 1:500 in oil; and Inhalant, Suppository, and Ointment.

PARKE, DAVIS & COMPANY

DETROIT 32 • MICHIGAN

Officers of the Maine Medical Association

1945-1946

OFFICERS

President, Adam P. Leighton, M. D., Portland
President-Elect, John O. Piper, M. D., Waterville
Secretary-Treasurer, Frederick R. Carter, M. D., Portland
Assistant Secretary, Esther M. Kennard, Portland

COUNCILORS AND DISTRICTS

First District,	Cumberland, York	Waldron L. Morse, M. D., Springvale,	1948
Second District,	Androscoggin, Franklin, Oxford	Ralph A. Goodwin, M. D., Auburn,	1948
Third District,	Knox, Lincoln, Sagadahoc	C. Harold Jameson, M. D., Rockland,	1947
Fourth District,	Kennebec, Somerset, Waldo	Roland L. McKay, M. D., Augusta,	1947
Fifth District,	Hancock, Washington	Harold S. Babcock, M. D., Castine,	1946
Sixth District,	Aroostook, Penobscot, Piscataquis	Forrest B. Ames, M. D., Bangor,	1946

CHAIRMEN OF COMMITTEES

Scientific
Ralf S. Martin, M. D., Portland

Medical Education and Hospitals
D. Allan Craig, M. D., Bangor

Medical Advisory
Allan Woodcock, M. D., Bangor

Legislative
Frederick R. Carter, M. D., Portland

Public Relations
Frederick T. Hill, M. D., Waterville

Cancer
Julius Gottlieb, M. D., Lewiston

Social Hygiene
Oscar R. Johnson, M. D., Portland

Publicity
Frederick R. Carter, M. D., Portland

The Journal of the Maine Medical Association

Published monthly at 142 High Street, Portland 3, Maine, under the direction of the Council

The Journal assumes no responsibility for opinions and statements of contributors. All copy, original articles, case reports, etc., will be submitted for publication typewritten on standard size paper and double spaced. Proof sheets furnished author on request. Address, 142 High Street.

Reprints

Communicate at once with the Marks Printing House, P. O. Box 384, Portland 3, Maine, if reprints of articles are wanted.

Entered as second-class matter December 22, 1926, at the post office at Portland, Maine, under the act of August 24, 1912.

$2.00 per year, 20c per copy.

Contents